

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL

89

MEDICAL CERTIFICATION

03123

JOHN

HOLMES

ABEON

MARCH

ALLEANY

USA

CUMBERLAND

WATLAND

JOHN

ABBOTT

MARGARET

W. O. 1

215 TO ROAD E. ORIAL HOSP. CUMBERLAND, CO.

XX

DR. WEISMAN

32 GREENE ST., CUMBERLAND, MD.

3/21/49

Realtime Memorial Gardens Cumberland, Md.

Accompanying

U. Wayne George Cumberland, Maryland

03154

CERTIFICATE OF DEATH

03149

1. DECEASED NAME (Type or print)		First JACOB		Middle H.		Last ALLISON		2a. DATE OF DEATH Month MARCH Day 2, Year 1969		2b. HOUR 6:50 M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 07-18-88		6. AGE (In years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS 80		IF UNDER 24 HRS. DAYS 80 HOURS 50 MIN	
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY CELANESE CORP					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN FLINSTONE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER ROUTE # 2			
14. FATHER'S NAME First GABRIEL		Middle B.		Last ALLISON		15. MOTHER'S MAIDEN NAME First SARA		Middle HARBAUGH		Last HARBAUGH	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 214-05-8450		17. INFORMANT Address HOSP. RECORD, 900 SETON DRIVE, CUMB., MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral aneurysm of lung 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 2/20, 1969 , to 3/2, 1969 , that (I) (we) last saw the deceased alive on 2/22, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE S. G. WEISMAN		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/4/69					
22d. PHYSICIAN'S NAME (Type) S. G. WEISMAN, M.D.		22e. ADDRESS 59 GREENE ST., CUMB., MD. 21502									
23a. BURIAL, CREMATION, REMOVAL, ETC. BURIAL		23b. DATE MARCH 5, 1969		23c. NAME OF CEMETERY OR CREMATORY HILLCREST BURIAL PARK		23d. LOCATION (City or Town) (County) (State) CUMBERLAND ALLEGANY MD.					
24. FUNERAL DIRECTOR SILCOX FUNERAL HOME, CUMB., MD.		ADDRESS		25a. REC'D BY REGISTRAR DATE MAR 5 1969		25b. REGISTRAR'S SIGNATURE S. G. WEISMAN					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15
45M . 1

22300

17000 .H. ALLISON MARCH 5, 1960 05:00

07-18-80 WHITE

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

FLINTSTONE ROUTE 12

GABRIEL VILLON 279A HALL/UGH

514-05-450 HOSTS RECORD, 900 SETON DRIVE, CUMING, MO.

NO 12 11 10 9 8 7 6 5 4 3 2 1 0

2110X FURNEL HOME, CMB., MD.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03155

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03150

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year			2b. HOUR A		
Blanche Virginia Ashby						March 16, 1969			3:07		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR A
Female	White	Sept. 15, 1912	56 YRS.					March 16, 1969			3:07 M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Virginia		U.S.A.				Allegany Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			Sacred Heart Hospital			None					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Virginia			Fauquier		Marshall				Star Route		
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
N. Gilbert Ashby				Rose A. Weadon							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT ADDRESS					
No				224-48-8761		B.F. Bragg, LaVale, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis, generalized</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Carcinoma of Ascending Colon</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 Months</u> <u>1 Year</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Benedict Skitarellic</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED <u>March 16, 1969</u>			
EXAMINER'S NAME (Type) <u>Benedict Skitarellic, M.D.</u>				ADDRESS (Street, city, town, or county) <u>Cumberland, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		3/19/69		Orlean Cemetery		Orlean, Fauquier, Virginia					
24. FUNERAL DIRECTOR <u>Charles E. Hafer</u>						25a. REC'D BY REGISTRAR DATE <u>MAR 18 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
Charles E. Hafer, 230 Balto. Ave., Cumberland, Md.											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03156 CERTIFICATE OF DEATH 03151									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
LEWIS			R. AYERS			3 Month 16 Day 69 Year			1:00 M
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
MALE	WHITE		12 25 11			57 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
PENNA.		USA				ALLEGANY Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND			SACRED HEART HOSPITAL			RAILROAD			
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			ALLEGANY		CUMBERLAND			221 GLEASON STREET	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
JOHN			AYERS			MARY E. (BONHEIMER) AYERS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No			214 07 4311		SACRED HEART HOSPITAL		900 SETON DRIVE CUMBERLAND, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bilateral Lobar Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Malignant Lymphoma, Lymphocytic type</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>12/30, 1968</i> , to <i>3/16, 1969</i> , that (I) (we) lost saw the deceased alive on <i>3/16, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			22c. DATE SIGNED						
<i>[Signature]</i>			<i>3/17/69</i>						
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
DR. J.A. PAGAN			M.D. 1068 NATIONAL HWY -LAVALE, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial			3/19/69			Hillcrest Burial Park		Cumberland Allegany Maryland	
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
SILCOX -MERRITT FUNERAL			404 DECATUR -CUMB., MD.			MAR 20 1969 <i>[Signature]</i>			

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08121

NO	214 07 4311	SACRED HEART HOSPITAL	WARY E. (BOHNEHEIM) AYERS	221 CLEGG STREET	CHURCHLAND, MD.
JOHN	AYERS				
WALYALAH	ALLEGRY, CHERLAND				
CHURCHLAND	SACRED HEART HOSPITAL	LOUL CAU			
USA					
WHITE	11 25 11				
LEWIS	W. AYERS				
1:00					

2140X - HENRITT FINEAL - CHURCHLAND, MD. - 11 25 11

100 NATIONAL HWY - LANGLEY, MARYLAND

W. J. A. RAGAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03157									
CERTIFICATE OF DEATH									
03152									
1. DECEASED-NAME (Type or print) Margaret Mae Barnes					2a. DATE OF DEATH at 2:00 P.M. Month March Day 29 Year 1969		2b. HOUR P.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 6/28/1881		6. AGE (In years lost birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany County Md.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Allegany County Infirmary		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 312 Arch Street	
14. FATHER'S NAME First Jacob Middle Bell Last Bell			15. MOTHER'S MAIDEN NAME First Sarah Middle Jane Last Householder						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 220-28-9749		17. INFORMANT P. O. Box 599, Cumberland, Md. Allegany County Infirmary records.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4369 IMMEDIATE CAUSE (a) CVA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Ischemic heart disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Month year year									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from May 7, 1954 , to March 29 1969 , that (I) (we) lost saw the deceased alive on 3/28 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE George M. Simons DEGREE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) George M. Simons					22e. ADDRESS Memorial Hospital, Cumberland, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Apr. 1, 1969		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR James P. Scarpelli, Cumberland, Md. ADDRESS James P. Scarpelli					25a. REC'D BY REGISTRAR APR 3 1969 DATE		25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03158										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03153									
1. DECEASED NAME (Type or print)										20. DATE OF DEATH										2b. HOUR									
First Middle Last										Month Day Year										A.M. P.M.									
FRANK S. BEAVER										MARCH 10, 1969										4:00 A.M.									
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (In years last birthday)					IF UNDER 1 YEAR MONTHS					IF UNDER 24 HRS. HOURS MIN.				
MALE					WHITE					APRIL 5, 1880					88 YRS.														
70. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH														
PENNSYLVANIA					U.S.A.										ALLEGANY														
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
FROSTBURG					MINERS HOSPITAL					SALESMAN					NAT'L. BISC.														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER									
MARYLAND					ALLEGANY					FROSTBURG					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					R.F.D. FROSTBURG, MD. PARKERSBURG ROAD, ECKHART									
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last																								
WILLIAM HARRY BEAVER					ANNIE GARLINGER																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					(If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					ECKHART, R.F.D. FROSTBURG, MD. 21532														
NO					N.A.					386-09-8839					MR. RALPH BOWSER, PARKERSBURG ROAD,														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arterio-sclerotic heart disease</u>															15 yrs.														
4121 DUE TO, OR AS A CONSEQUENCE OF <u>Hypertension</u>																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chl. Nephritis</u>																													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Senility</u>																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <u>3-1</u> , 19 <u>67</u> , to <u>3-10</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3-10</u> , 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <u>H.C. Diehl, M.D.</u> DEGREE <u>M.D.</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED <u>3/11/69</u>																			
22d. PHYSICIAN'S NAME (Type) <u>H. C. DIEHL, M.D.</u>										22e. ADDRESS <u>39 W. MAIN ST., FROSTBURG, MD.</u>																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
BURIAL					3/12/69					SCHELLSBURG CEMETERY					SCHELLSBURG, BEDFORD, PA.														
24. FUNERAL DIRECTOR <u>MARTLOU M. SOWERS, HAFER-SOWERS FUNERAL</u> ADDRESS <u>HOME, 60 W. MAIN, FROSTBURG</u> DATE <u>MAR 14 1969</u> 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>																													

03128

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NAME: [illegible] SEX: [illegible] DATE OF BIRTH: [illegible]

WHITE

U.S.A.

ALABAMA

MOBILE

RECEIVED

NO. 100-100000

[illegible]

[illegible]

[illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03159		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03154	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)		First LENA	Middle K.	Last BEGGS	2a. DATE OF DEATH MARCH Month 21 Day 1969 Year		2b. HOUR 4:20 P.M.
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH NOVEMBER 27, 1893		6. AGE (In years last birthday) 75 YRS.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.	
10. CITY OR TOWN OF DEATH FROSTBURG		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MINERS HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NURSE		12b. KIND OF BUSINESS OR INDUSTRY PRIVATE	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN MT. SAVAGE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First SAMUEL		Middle KELLY		Last CATHERINE		15. MOTHER'S MAIDEN NAME First NEAL	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 215-60-5041		17. INFORMANT HOSPITAL RECORD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Hemorrhage</u> 4214 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic CVD</u> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 hrs. 10 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION <input checked="" type="checkbox"/>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <input checked="" type="checkbox"/>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <input checked="" type="checkbox"/>			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <input checked="" type="checkbox"/>		21f. LOCATION Street or R.F.D. No. City or Town County State <input checked="" type="checkbox"/>			
22a. I certify that (I) (this hospital) attended the deceased from <u>196</u> , to <u>21 MARCH, 1969</u> , that (I) (we) last saw the deceased alive on <u>21 MARCH 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Martin M. Rothstein</u>				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN				22c. DATE SIGNED 3-25-69			
22e. ADDRESS 48 BROADWAY, FROSTBURG, MARYLAND, 21532				22f. ADDRESS 48 BROADWAY, FROSTBURG, MARYLAND, 21532			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE MAR. 24, 1969		23c. NAME OF CEMETERY OR CREMATORY EPISCOPAL CEMETERY		23d. LOCATION (City or Town) (County) (State) MT. SAVAGE, MD.	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. 21532				ADDRESS 48 BROADWAY, FROSTBURG, MD. 21532		25a. REC'D BY REGISTRAR MAR 26 1969	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month 03 Day 06 Year 69		2b. HOUR A 5:45M	
ARTHUR		J.		BELCHER				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 09-11-01		6. AGE (In years last birthday) 67 YRS.		
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY COUNTY Md.		
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) MACHINE OPERATOR		12b. KIND OF BUSINESS OR INDUSTRY TIRE & RUBBER		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN LA VALE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 517 NATIONAL HIGHWAY		14. FATHER'S NAME First Middle Last RICHARD BELCHER		15. MOTHER'S MAIDEN NAME First Middle Last (MERRILL) FANNIE BELCHER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 297-10-6622		17. INFORMANT Address SACRED HEART, 900 SETON DR., CUMB., MD. 21502				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma, Spine</u> DUE TO, OR AS A CONSEQUENCE OF <u>Primary Site Undetermined.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>11-14</u> , 19 <u>69</u> , to <u>3-6</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Dec. 4</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Calvin Y. Hadidian, M.D.</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/6/69		
22d. PHYSICIAN'S NAME (Type) C.Y. HADIDIAN, M.D.		22e. ADDRESS WASHINGTON & CUMBERLAND ST., CUMB., MD.						
23a. BURIAL, CREMATION, REINTERMENT BURIAL		23b. DATE MARCH 8, 1969		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION (City or Town) (County) (State) Meyersdale Somerset PA.		
24. FUNERAL DIRECTOR H. LEE SILCOX 404 DECATUR STREET CUMBERLAND MD		ADDRESS		25a. REC'D BY REGISTRAR DATE MAR 7 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

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2025-01-22 RECORDED HEALTH.

WASHINGTON & CONSERVATION CLUB

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03161

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03156

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year			2b. HOUR		
Noel			Beverlin			OF ESTI- DEATH MATED <input type="checkbox"/> March 23, 1969			12:45 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD			2d. HOUR
Male	White	June 13, 1905	63 YRS.					March 23, 1969			12:45 PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
West Va		U.S.A.				Allegany					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			Memorial Hospital--DOA			Steel Worker					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Allegany		Cumberland				214 Frederick Street		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last William Thomas Beverlin			First Middle Last Victoria Elizabeth Bonnell								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			
Yes			WW II		Edna Beverlin			214 Frederick St Cumberland, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS, LEFT 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Coronary Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) ----- APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			BENEDICT SKITARELIC, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			March 23, 1969		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial		3/26/69		Center Point Cemetery			Salem Harrison W. Va				
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Silcox-Merritt Funeral Service. Cumberland, Md			21502			MAR 26 1969			Charles Judge		

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

03162				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03157											
1. DECEASED-NAME (Type or print)				First Middle Last				2a. DATE OF DEATH				2b. HOUR							
RAY				JACKSON				BOYD				Month Day Year MARCH 4, 1969				P. 6:00			
3. SEX MALE				4. RACE WHITE				5. DATE OF BIRTH JUNE 14, 1898				6. AGE (In years last birthday) 70 YRS.				7. UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) IOWA				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH ALLEGANY Md.							
10. CITY OR TOWN OF DEATH R.F.D. FROSTBURG				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) R.F.D. 1, FROSTBURG				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FOREMAN				12b. KIND OF BUSINESS OR INDUSTRY GLASS FACT.							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND				13b. COUNTY ALLEGANY				13c. CITY OR TOWN FROSTBURG				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET AND NUMBER R.F.D. 1, BOX 285, FROST-			
14. FATHER'S NAME First Middle Last FRANK BOYD				15. MOTHER'S MAIDEN NAME First Middle Last GRACE DOWNEY				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) YES W. WAR I				16b. SOCIAL SECURITY NO. 338-28-0535				17. INFORMANT FROSTBURG, MD. MRS. RAY J. BOYD, R.F.D. 1, BOX 285.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>4122</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>H.C.U.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 years</u>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 23, 1969</u> , to <u>March 4, 1969</u> , that (I) (we) last saw the deceased alive on <u>March 4, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <u>(did)</u> (did not) view the body after death.																			
22b. SIGNATURE <u>John B. Davis</u>				DEGREE M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <u>3/6/69</u>							
22d. PHYSICIAN'S NAME (Type) JOHN B. DAVIS, M.D.				22e. ADDRESS 2 BROADWAY, FROSTBURG, MD.															
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE 3/7/69				23c. NAME OF CEMETERY OR CREMATORY ECKHART CEMETERY				23d. LOCATION (City or Town) (County) (State) ECKHART ALLEGANY, MD.							
24. FUNERAL HOME <u>Marlow M. Sowers</u>				M. SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG				25a. REC'D BY REGISTRAR MAR 11 1969				25b. REGISTRAR'S SIGNATURE <u>Charles George</u>							

03163

03163

OFFICE OF THE

NAME: JAMES H. BOND

DATE: JAN 14 1968

TIME: 10:00 AM

PLACE: (blank)

REASON: (blank)

BY: (blank)

FOR: (blank)

FILE: (blank)

REMARKS: (blank)

SIGNATURE: (blank)

DATE: (blank)

TIME: (blank)

PLACE: (blank)

REASON: (blank)

BY: (blank)

FOR: (blank)

FILE: (blank)

REMARKS: (blank)

SIGNATURE: (blank)

DATE: (blank)

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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03163

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03158

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First John			Middle Frederick			Last Brode			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 3-16 1969			2b. HOUR 12A M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH Sept. 4, 1902		6. AGE (In years last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month 3 Day 16 Year 1969			2d. HOUR 12A M				
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Allegany Md.										
10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sacred Heart Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Machinist helper				12b. KIND OF BUSINESS OR INDUSTRY Railroad							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Allegany				13c. CITY OR TOWN Cumberland				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER 325 Greene St.			
14. FATHER'S NAME First John Middle C. Last Brode						15. MOTHER'S MAIDEN NAME First Ella Fitzgerald Middle Last													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16b. SOCIAL SECURITY NO. (If yes give war or dates of service)				17. INFORMANT ADDRESS Mrs. Gertrude Brode, Cumberland, Md. Wife											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>---</u>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED March 16, 1969							
EXAMINER'S NAME (Type) Dr. Benedict Skitarelic M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
ADDRESS (Street, city, town, or county) Rt. 9, Cumberland, Md.																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 3-19-69				23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery				23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.							
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.						25a. REC'D BY REGISTRAR DATE MAR 19 1969				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									

08157

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
SOLOMON			HENRY BRODE			Month 03 Day 13 Year 69		1:00 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
MALE		WHITE		02-13-00		69 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		U.S.A.				ALLEGANY COUNTY Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		SACRED HEART HOSPITAL		BEER DISTRIBUTOR - CUM. BREWING CO.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
WEST VIRGINIA MINERAL			KEYSER				RT. #4, BOX 70		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
SOLOMON BRODE			(MERRILL) KATE S. BRODE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO			214-05-4748		SACRED HEART, SETON DR., CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>CA OF PROSTATE</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>L. M. GELICK</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-13-69		
22d. PHYSICIAN'S NAME (Type) <u>L. M. GELICK MD</u>					22e. ADDRESS <u>912 SETON DR</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		3-17-1969		FROSTBURG MEMORIAL		FROSTBURG, ALLEG. MD.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
DURST FUNERAL HOME, 57 FROST AVE., FROSTBURG, MD.				MAR 18 1969		<u>William Judge</u>			

SECTION 2

HEIRY

31006

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00:1

MALE

WHITE

00-11-00

00

ALLEGANY COUNTY

WYOMING

11-2-1

SACRED HEART HOSPITAL

CHURCHLAND

WEST VIRGINIA MINERAL KEYSER

RT. 1, BOX 70

SECTION 2

31006

(MERRILL) DATE

2

31006

21A-02-17A SACRED HEART, SECTION 01, CHURCHLAND, MD.

END

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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03165										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03160									
Item 7 Film 6410 3/17/69 kk										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH Month Day Year					2b. HOUR A														
FRANCES					A.					BUDRIES					Month 03 Day 06 Year 69					4:35 M									
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (In years last birthday)					IF UNDER 1 YEAR MONTHS DAYS HOURS MIN									
FEMALE					WHITE					01 15 1895					74 YRS.														
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH					Md.									
LITHUANIA					Lithuania										ALLEGANY COUNTY														
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give the address)					12a. USUAL OCCUPATION (Kind of work done during most of last year, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
CUMBERLAND					SACRED HEART HOSPITAL					HOUSEWIFE																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER									
MARYLAND					ALLEGANY					NIKEP										NIKEP, MARYLAND 21546									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																								
First Middle Last					First Middle Last																								
John					PEAR					ANNA					PEAR														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address					MD. 21502									
NO					182-01-6414					SACRED HEART HOSPITAL, 900 SETON DR., CUMB.,																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>										20 hrs.																			
4122 DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) <u>Hypertensive Cardiovascular Disease</u>										work									
										(c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/5, 1969</u> , to <u>3/6, 1969</u> , that (I) (we) last saw the deceased alive on <u>3/5, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED									
22d. PHYSICIAN'S NAME (Type) <u>J.A. PAGAN, M.D.</u>										22e. ADDRESS										<u>1068 NATL. HWY., LA VALE, MD. 21502</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					3/8/1969					St. Gabriels Cemetery					Barton, Md.														
24. FUNERAL DIRECTOR										ADDRESS										MD. 21532									
EICHORN FUNERAL HOME, 8 E. MAIN ST., LONACONING										MAR 12 1969										25b. REGISTRAR'S SIGNATURE									

• *Noted*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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03166

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03161

1. DECEASED-NAME (Type or print)		First MARY	Middle E.	Last CARDER	2a. DATE OF DEATH MARCH Month 25 Day 1969 Year		2b. HOUR 11:35 P M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 11-11-84		6. AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. HOURS 0	MIN. 0
7a. BIRTHPLACE (State or foreign country) PENNA.		7b. CITIZEN OF WHAT COUNTRY? USA		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY				
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housekeeper - At Home		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 451 WAVERLY TERRACE		
14. FATHER'S NAME ELICK		First ELICK	Middle EMERICK	Last CARA		15. MOTHER'S MAIDEN NAME JANE KENNEL		First JANE		Middle KENNEL
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 212-05-0788D		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4319 <i>Haemia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Massive Cerebral Hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 5 days 5 yrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan. 20, 1969 , to March 25, 1969 , that (I) (we) last saw the deceased alive on March 25, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Clay E. Durrett</i>					DEGREE CLAY E. DURRETT, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/26/69	
22d. PHYSICIAN'S NAME (Type) CLAY E. DURRETT, M.D.					22e. ADDRESS 236 VIRGINIA AVE., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/28/69		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland				
24. FUNERAL DIRECTOR Silcox-Merritt Funeral Service, Cumberland, Md					ADDRESS 21502		25a. REC'D BY REGISTRAR APR 1 1969		25b. REGISTRAR'S SIGNATURE <i>W. C. ...</i>	

03160

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ANY E. JUNE 1941

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03167					03162				
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <i>Katherine</i>		Middle <i>J.</i>		Lost <i>COBLE</i>		2a. DATE OF DEATH 3 Month 11 Day 69 Year		2b. HOUR 12:45 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 12/26/05		6. AGE (In years last birthday) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.			
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) BOOKKEEPER-ROBISON		12b. KIND OF BUSINESS OR INDUSTRY PLUMBING & HEATING			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN LA VALE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 540 NATIONAL HWY.	
14. FATHER'S NAME First Middle Last GEORGE <i>Stoval</i>		15. MOTHER'S MAIDEN NAME First Middle Last (PRESSMAN) LENA STOBALL		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) NO					
16b. SOCIAL SECURITY NO. 214 05 8352		17. INFORMANT PATIENT'S HOSPITAL CHART				Address 900 SETON DRIVE CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis</i> 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Benign prostatic hyperplasia</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov 1968</i> , to <i>1 Mar 1969</i> , that (I) (we) last saw the deceased alive on <i>10 Mar 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>F. Miltenberger</i>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>12 Mar 1969</i>			
22d. PHYSICIAN'S NAME (Type) DR. F. MILTENBERGER		22e. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD. 21502							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3/14/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Restlawn Memorial Ph.</i>		23d. LOCATION (City or Town) (County) (State) <i>Cumberland Allegany Md</i>			
24. FUNERAL DIRECTOR <i>Stein's Funeral Home</i>		ADDRESS <i>117 Frederick St.</i>		25a. CREATOR PRESTIGER <i>17 1969</i>		25b. REGISTRAR'S SIGNATURE <i>W. H. H. H.</i>			

STEIN'S FURNITURE

117 FREDERICK ST.
CUMBERLAND, MD.

DR. F. WILBERGER

122 S. CENTRE ST., CUMBERLAND, MD. 21202

NO

214 02 0322

PATIENT'S HOSPITAL CHART

CUMBERLAND, MD.
500 SOUTH WILKINSON

GEORGE

STODOL

(PRESSMAN) LENA

STODOL

LORELYND

ALLEGANY

LA WALE

X

240 NATIONAL HWY.

CUMBERLAND, MD.

SACRED HEART HOSPITAL

BOOKKEEPER-ROBERT PLUMBING

117

VIRGINIA

UNITED STATES

ALLEGANY

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WHITE

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CO

KATHY

LOUISE

COLE

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11

CO

12/12

03167

CENTRAL DEPT.

03167

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03168

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03163

1. DECEASED-NAME (Type or Print) John Richard Colmer			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year March 24-69			2b. HOUR 2:30 a		
3. SEX Male	4. RACE White	5. DATE OF BIRTH Feb. 28, 1951	6. AGE (In years last birthday) 18 YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month March Day 24 Year 1969 Hour 2:30 a M		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany,		
10. CITY OR TOWN OF DEATH Cumberland,		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital--DOA		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Auto shop employt,		12b. KIND OF BUSINESS OR INDUSTRY Auto Shop		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland,		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 13 Ave. L, Potomac Park,
14. FATHER'S NAME First Olen Middle C. Last Colmer			15. MOTHER'S MAIDEN NAME First Betty Middle A. Last Miller					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No,		16b. SOCIAL SECURITY NO. 215-56-8840		17. INFORMANT ADDRESS Olen C. Colmer 13 Ave. L., Potomac Park, Cumb Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation (blood in bronchi) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 8199 (b) Compression of Lungs DUE TO, OR AS A CONSEQUENCE OF (c) Crushed Chest								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes " Sudden
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 1:30 PM March 24, '69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Automobile Accident (one car)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Highway		21f. LOCATION Street or R.F.D. No. City or Town County State Winchester Road, Cumberland, Allegany, Maryland				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Benedict Skitarelic			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			March 24, 1969		
ADDRESS (Street, city, town, or county) Cumberland, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/26/69		23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Nr. Barton, Allegany Md.		
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.				25a. REC'D BY REGISTRAR DATE APR 1 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03169										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03164																																							
Item 6 Film 10 3/18/69 kk										CERTIFICATE OF DEATH																																																	
1. DECEASED-NAME (Type or print) First Middle Last William C. Crabtree										2a. DATE OF DEATH Month Day Year 3 11 69										2b. HOUR 2:45 P M																																							
3. SEX Male										4. RACE White										5. DATE OF BIRTH 3/1/86										6. AGE (In years last birthday) 83 84 YRS.										IF UNDER 1 YEAR MONTHS DAYS HOURS MIN										IF UNDER 24 HRS. HOURS MIN									
7a. BIRTHPLACE (State or foreign country) Maryland										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Allegany County Md.																													
10. CITY OR TOWN OF DEATH Cumberland										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Allegany County Infirmary										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Farmer										12b. KIND OF BUSINESS OR INDUSTRY Self																													
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland										13b. COUNTY Allegany										13c. CITY OR TOWN Oldtown										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER Rt. #1, Oldtown, Maryland																			
14. FATHER'S NAME First Middle Last Levi Crabtree										15. MOTHER'S MAIDEN NAME First Middle Last Emmaline Twigg																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No										16b. SOCIAL SECURITY NO. 220-28-9631-A										17. INFORMANT P.O. Box 599, Cumberland, Md.																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>acute cerebro-vascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arterio Sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chr. A.S.H.D. & mitral insufficiency</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Chr. Brain Syndrome - C.V.A. 11/62. Chr. Bronchitis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Four hours</u> <u>many years</u> <u>many years</u>																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 24, 1969</u> , to <u>March 11, 1969</u> , that (I) (we) lost saw the deceased alive on <u>March 10, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE <u>John A. Topper</u>										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>										22c. DATE SIGNED <u>3-12-69</u>																																							
22d. PHYSICIAN'S NAME (Type) <u>John A. Topper</u>										22e. ADDRESS <u>Memorial Hospital, Cumberland, Md.</u>																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>										23b. DATE <u>3/14/1969</u>										23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cemetery</u>										23d. LOCATION (City or Town) (County) (State) <u>Near Oldtown Alleg Md</u>																													
24. FUNERAL DIRECTOR <u>John J. Hafer, Jr.</u>										ADDRESS <u>230 Balto Ave. Cumberland Md.</u>										25a. REC'D BY REGISTRAR <u>MAR 14 1969</u>										25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>																													

03162

03162

THE BUREAU OF BEACH

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03170

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03165

1. DECEASED-NAME (Type or Print)		First Ada		Middle Crites		Last		2a. DATE KNOWN OF DEATH		Month March		Day 5, 1969		Year 1969		2b. HOUR 3a M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH Oct. 10, 1929		6. AGE (in years and birthday) 39 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD Month March		Day 5, 1969		Year 1969		2d. HOUR 4 a M	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? Allegany		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany													
10. CITY OR TOWN OF DEATH Rt. 1, Oldtown, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rt. 1, Oldtown, Md.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Oldtown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER None											
14. FATHER'S NAME Thomas		First Thomas		Middle Naill		Last		15. MOTHER'S MAIDEN NAME Jessie P. Leasure		First Jessie P.		Middle Leasure		Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Mr. Sterling Crites, Oldtown, Md. - Husband		ADDRESS													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot of chest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>(self inflicted)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>955 X</u>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State															
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Not known Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED March 5, 1969									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 8, 1969		23c. NAME OF CEMETERY OR CREMATORY Oliver Grove Cemetery		23d. LOCATION (City or Town) (County) (State) Oldtown, Md. Allegany													
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR MAR 6 1969		25b. REGISTRAR'S SIGNATURE <u>James F. Scarpelli</u>													

07160

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15
30M REV 168

03171		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03166			
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
William Edward Crowe						March 27 1969		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		8/20/1894		74 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Maryland		U.S.A				Allegany		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Frostburg		Miners Hospital		Retired		Kelly Tire Co			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md		Allegany		Lonaconing				Detmold Street	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Clarence Crowe						Sarah Thompson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT				Address
1st W.W					Mrs. Alden Fuente				Lonaconing, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Chronic Pulmonary Fibrosis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from _____, 1968, to <u>Mar. 27, 1969</u> , that (I) (we) last saw the deceased alive on <u>Mar. 27, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>L.R. Miles, Jr. MD</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 3-27-69				
22d. PHYSICIAN'S NAME (Type) L.R. MILES, JR., M.D.					22e. ADDRESS LONACONING, MD. 21539				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		3/30/69		Laurel Hill Cemetery		Moscow		A.	Md
24. FUNERAL DIRECTOR George Eichhorn					ADDRESS Lonaconing, Md.		25a. REC'D BY REGISTRAR MAR 28 1969 DATE		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>

0317

William Edward Grove

Male

1911

8/20/1898

Albany

Residence: 1111 Broadway, New York City

Occupation: Attorney at Law

Education: Harvard University, A.B., 1911

Married: 1915, Mary Elizabeth (nee) Smith

Children: 1. John Edward, born 1916

2. William Edward, born 1918

3. Mary Elizabeth, born 1920

4. Robert Lee, born 1922

5. Elizabeth Ann, born 1924

6. Charles William, born 1926

7. Thomas Henry, born 1928

8. Margaret Ann, born 1930

9. John William, born 1932

10. William Edward, born 1934

11. Mary Elizabeth, born 1936

12. Robert Lee, born 1938

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1/69

03172		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03167			
Item 5 Film 411 4/10/69 kk									
1. DECEASED-NAME (Type or print)		First MARY		Middle M.	Lost CULLEN		2a. DATE OF DEATH 3 Month 31 Day 69 Year	2b. HOUR 10:55A	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 04 05 88 1887		6. AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.			
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN MIDLAND		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First JOHN		Middle BRYSON		Last BRYSON		15. MOTHER'S MAIDEN NAME First ANNA			Last BRYSON
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT PATIENT'S HOSPITAL CHART			Address 900 SETON DRIVE CUMBERLAND, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Death Myocardial Infarct</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetic Mellitus</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 3-31-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>B. M. Miller</u>		22c. DATE SIGNED 3-31-69		22d. PHYSICIAN'S NAME (Type) 22e. ADDRESS 22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/2/69		23c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery		23d. LOCATION (City or Town) Frostburg		(County) A.	(State) Md
24. FUNERAL DIRECTOR EICHORN FUNERAL HOME		ADDRESS 8 E MAIN ST LONACONING, MD		25a. REC'D BY REGISTRAR DATE APR 7 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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EICHORFF FUNERAL HOME

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03178										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03168			
1. DECEASED-NAME (Type or print) First Middle Last GEORGE W. CUTTER										2a. DATE OF DEATH MARCH Month 10 Day 1969 Year										2b. HOUR M			
3. SEX MALE				4. RACE WHITE				5. DATE OF BIRTH NOVEMBER 30, 1900				6. AGE (In years last birthday) 68 YRS.				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (State or foreign country) MARYLAND				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH ALLEGANY Md.											
10. CITY OR TOWN OF DEATH FROSTBURG				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) D.O.A. MINERS HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) AUTO MECHANIC				12b. KIND OF BUSINESS OR INDUSTRY GARAGE											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND				13b. COUNTY ALLEGANY				13c. CITY OR TOWN FROSTBURG				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 30 BLAIR STREET									
14. FATHER'S NAME First Middle Last BARNEY CUTTER				15. MOTHER'S MAIDEN NAME First Middle Last JEAN McMURDO																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO				16b. SOCIAL SECURITY NO. 212-03-5413				17. INFORMANT Address MRS. AGNES B. CUTTER, FROSTBURG, MD. 21532															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Coronary Occlusion</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic Pulmonary Fibrosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State															
22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 19 <u>66</u> , to <u>3-10</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3-3</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE <u>Martin Rothstein</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED <u>3-10-69</u>			
22d. PHYSICIAN'S NAME (Type) MARTIN ROTHSTEIN, M. D.				22e. ADDRESS 48 BROADWAY, FROSTBURG, MD.																			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE MAR. 13, 1969				23c. NAME OF CEMETERY OR CREMATORY FBG. MEMORIAL PARK				23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.											
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. 21532				25a. REC'D BY REGISTRAR DATE MAR 18 1969				25b. REGISTRAR'S SIGNATURE <u>Blanche Judgel</u>															

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**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03174

MARYLAND DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03169

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>		Month	Day	Year	2b. HOUR		
JOSEPH HAROLD DETER										3	3	1969	2 P M		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR			
MALE	WHITE	4/3/1918		50 YRS.		MONTHS DAYS		HOURS MIN.		3 Month 3 Day 1969		2 P M			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH									
MARYLAND		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		ALLEGANY		Md.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY									
CUMBERLAND		DOA MEMORIAL HOSPITAL		MACHINIST		RAILROAD									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER							
MARYLAND		ALLEGANY		CUMBERLAND		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		632 LEIPER STREET							
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last	
CHARLES DETER								ELIZABETH LINDNER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
NO		220 10 4885		MRS. JOSEPH H. DETER		CUMBERLAND, MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
CORONARY OCCLUSION												SUDDEN			
CORONARY SCLEROSIS												--			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hypertensive Cardiovascular Disease															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?											
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED					
EXAMINER'S NAME (Type)		BENEDICT SKITARELIC, M.D.		RT. 9, CUMBERLAND, MD.		MARCH 3, 1969									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)									
BURIAL		3/6/1969		TRINITY LUTHERAN CEM.		CUMBERLAND, MD.									
24. FUNERAL DIRECTOR		BYRON KIGHT		ADDRESS		25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
				CUMBERLAND, MD.		MAR 6 1969		[Signature]							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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03175

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03170

1. DECEASED-NAME (Type or print)		First JOHN	Middle FRANCIS	Last FEENEY	2a. DATE OF DEATH Month 24 Day 69 Year 3		2b. HOUR P 3:00 M				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 05/22/80		6. AGE (In years last birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) RHODE ISLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.					
1d. CITY OR TOWN OF DEATH CUMBERLAND, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MACHINE REPAIRER KELLY SPRINGFIELD TIRE CO.		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 409 BEALL STREET			
14. FATHER'S NAME First MICHAEL		Middle FEENEY		Last FEENEY		15. MOTHER'S MAIDEN NAME First ANN		Middle Kiernan		Last FEENEY	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. 214 07 0384		17. INFORMANT PATIENT'S HOSPITAL CHART		Address 900 SETON DRIVE CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>hypostatic pneumonia</u> 4122 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cardio-reno-vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>generalized arteriosclerosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 1 year 24 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>3-15-69</u> , to <u>3-24-69</u> , that (I) (we) last saw the deceased alive on <u>3-24-69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>H. Brings MD</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>3-25-69</u>					
22d. PHYSICIAN'S NAME (Type) DR. LEWIS BRINGS		22e. ADDRESS 57 GREENE ST., CUMBERLAND, MD. 21502									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/27/69		23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cem.		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.					
24. FUNERAL DIRECTOR H. Wayne George		ADDRESS Cumberland, Maryland		25a. REC'D BY REGISTRAR APR 1 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

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FRANCIS GREENE

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ALLEANY

RHODE ISLAND U. S. A.

COURTLAND, NO. 2 STORED NEAR HOSP. KELLY SPRINGFIELD FIRE CO.

HARVARD ALLEANY COURTLAND X 400 ELL STREET

MICHAEL FRENEY (RETIRED) 111 ALLEANY FRENEY

NO 214 07 0304 PATIENT'S HOSPITAL CHARGE
COURTLAND, U. S. A. 200 SEVENTH AVENUE

DR. LEWIS BRIDGES

27 GREENE ST., COURTLAND, XXX ID. 21502

25. PETER J. HARRIS, C.M.

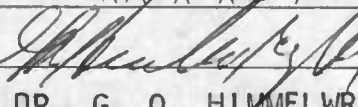

ALEXANDER, JR.

W. JAMES GEORGE, COUNSELLOR, HARRIS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
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03176		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		03171						
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)		First EFFIE	Middle P.	Last GANOE	2a. DATE OF DEATH Month MARCH 18 th 1969	2b. HOUR 9:28 PM				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 8-28-1893		6. AGE (In years last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) W. VA.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY				
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give name of home) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 430 ARCH ST.,		
14. FATHER'S NAME First JACOB		Middle THOMAS		Last MARY JANE MC ATEE		15. MOTHER'S MAIDEN NAME First Middle Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Heart Block</u> <u>4109</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Posterior Myocardial Infarction</u> (c) <u>Arteriosclerotic Cardiovascular Disease</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours 9 hours years				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>1954</u> , 19____, to <u>Mar. 18</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>March 18</u> 19 <u>69</u> , and that in (my) (or) apinian death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE 		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-19-61						
22d. PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT		22e. ADDRESS CUMBERLAND, MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3-21-1969		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany				
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR MAR 24 1969		25b. REGISTRAR'S SIGNATURE 				

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JACOB THOMAS

JACOB THOMAS

CUMBERLAND, MD.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

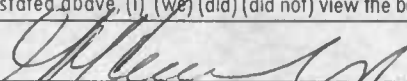
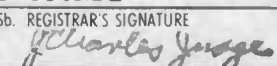
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03177

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03172

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First BERMAN	Middle N.	Last GARLITZ	2a. DATE OF DEATH Month 3 Day 15 Year 69		2b. HOUR 7:30A M.		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 12-21-13		6. AGE (In years last birthday) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FARM HAND		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY GARRETT		13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RT. 40	
14. FATHER'S NAME First WILLIAM Middle GARLITZ Last ROBISON		15. MOTHER'S MAIDEN NAME First ANNA Middle A. Last ROBISON		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give year or dates of service) WW 2		16b. SOCIAL SECURITY NO. 236-36-1805		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC COMA 5710 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CIRRHOSIS OF THE LIVER (c) CHRONIC ALCOHOLISM								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS MONTHS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ESOPHAGEAL VARIEES									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from MARCH 5, 1969 , to MARCH 14, 1969 , that (I) (we) last saw the deceased alive on MARCH 14, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE 				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-17-69			
22d. PHYSICIAN'S NAME (Type) DR. G.O. HIMMELWRIGHT				22e. ADDRESS CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3-18-69		23c. NAME OF CEMETERY OR CREMATORY BLOCHER CEMETERY		23d. LOCATION (City or Town) (County) (State) GARRETT COUNTY			
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR.,				ADDRESS FROSTBURG, MD. 21532		25a. REC'D BY REGISTRAR MAR 20 1969		25b. REGISTRAR'S SIGNATURE 	

03177

MALE
WHITE
12-21-13
CUMBERLAND, MD.
U.S.A.
ALLEGANY

CUMBERLAND
HOSPITAL
FROSTBURG
CARLITE
WILLIAM
ANNA
ROBINSON

CUMBERLAND HOSPITAL
CUMBERLAND, MD.

HEPATIC COMA
CIRRHOSIS OF THE LIVER
CHRONIC ALCOHOLISM
ESOPHAGEAL VARICES

MARCH 11, 1933
MARCH 18, 1933
CUMBERLAND, MD.
DR. G.O. HUMPHREY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

03178										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03173				
Item 13d Film 411 4/17/69 kk										CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH Month Day Year					2b. HOUR									
ELMER					F. GARLITZ					MARCH 18, 1969					3:20 A									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.														
MALE		WHITE		MAY 7, 1911		57 YRS.		MONTHS		DAYS		HOURS		MIN.										
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH									
MARYLAND					USA										ALLEGANY Md.									
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					12b. KIND OF BUSINESS OR INDUSTRY									
CUMBERLAND					SACRED HEART HOSPITAL					RETIRED-TRI-STATE ROOFING-ROOFING														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER				
MARYLAND					ALLEGANY					CUMBERLAND					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					HOMWOOD ADDITION				
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last																			
MICHAEL					GARLITZ					REBECCA					CEICE									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address									
NO					215-10-1253					PTS HOSP CHART					SACRED HEART HOSPITAL 900 SETON DRIVE CUMBERLAND, MD 21502									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>thrombotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>5 years</u>															1/2 from									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from 3-4-1969, to 3-18-1969, that (I) (we) last saw the deceased alive on 3-18-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE <u>L. Brings</u>										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 3-18-69									
22d. PHYSICIAN'S NAME (Type) <u>LEWIS BRINGS, MD.</u>										22e. ADDRESS <u>57 GREENE ST., CUMB., MD. 21502</u>														
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)									
Burial					3/21/69					Rest Lawn Memorial Gardens					LaVale Allegany Maryland									
24. FUNERAL DIRECTOR ADDRESS										25a. REC'D BY REGISTRAR DATE					25b. REGISTRAR'S SIGNATURE									
SILCOX FUNERAL HOME 404 DECATUR ST.										MAR 20 1969														

00110

DATE 3-17-44
 TIME 10:30
 PLACE 101 YLBN
 SUBJECT ALLEGY

CHURCHLAND
 101 YLBN
 ALLEGY
 SACRED HEART HOSPITAL
 1000 3RD ST
 CHURCHLAND, W. 2102

101 YLBN
 1000 3RD ST
 CHURCHLAND, W. 2102

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Warren Ellsworth Growden						March 18, 1969			12:30 a.m.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD			2d. HOUR
Male	White	Aug 17, 1901	67 YRS.					March 18, 1969			12:30 a.m.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH			2d. HOUR		
Penna		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Allegany			Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			MEMORIAL HOSPITAL			Retired Employee-Swift & Co.					
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Penna. Maryland			Allegany			Cumberland			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER					
Eli Growden			Bessie Richardson			Route #3					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			214-05-5888			Mrs. Frances Growden			Route #3 Cumberland, Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4109</u> CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a): stating the underlying cause lost. } (b) CORONARY THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY SCLEROSIS									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS " "		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			BENEDICT SKITARELIC, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			MARCH 18, 1969		
						ADDRESS (Street, city, town, or			CUMBERLAND, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		3/20/69		Sunset Memorial Park		Cumberland Allegany Maryland					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Silcox-Merritt Funeral Service. Cumberland, Md				21502				MAR 20 1969		Charles Judge	

9150

REF: 31 1991 11 30

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil. Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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03180

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03175

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month		Day		Year		2b. HOUR	
JACK		L.		HANSON, SR.				March 8, 1969		7:30a							
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		Month		Day		Year	
MALE	WHITE	APRIL 5, 1908		60 YRS.		MONTHS		DAYS		HOURS		MIN.		March 13, 1969		7:30	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH									
MARYLAND		U.S.A.		WIDOWED		DIVORCED		ALLEGANY									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY											
FROSTBURG		Miners Hospital--DOA		INSPECTOR - STATE ROADS													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER									
MARYLAND		ALLEGANY		FROSTBURG		YES		78 W. MAIN STREET									
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last			
WILLIAM		D.		HANSON				ANN						LEWIS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
NO		214-07-3674		JACK L. HANSON, JR.,		FROSTBURG, MD.		21532									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1. DEATH WAS CAUSED BY:		CORONARY OCCLUSION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		SUDDEN									
4109		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		CORONARY SCLEROSIS		---											
(c)		DUE TO, OR AS A CONSEQUENCE OF															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES		NO									
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State							
22a. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner							
ACTUAL SIGNATURE		Benedict Skitarelic		M.D.		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		22b. DATE SIGNED		March 13, 1969			
EXAMINER'S NAME (Type)		BENEDICT SKITARELIC, M.D.		ADDRESS (Street, city, town, or county)		Cumberland, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)							
BURIAL		MAR. 16, 1969		FBC. MEMORIAL PARK		FROSTBURG, MD.											
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
JOSEPH R. DURST, SR.,		FROSTBURG, MD.		21532		DATE		MAR 18 1969									

03180

03180

RECEIVED
MAR 1 1968
U.S. AIR FORCE
OFFICE OF THE
JOINT CHIEFS OF STAFF
WASHINGTON, D.C.
20330-1000
ATTENTION: JCS-1000
FROM: [illegible]
SUBJECT: [illegible]
[illegible text follows]

ADMINISTRATIVE
[illegible text follows]

1. [illegible]
2. [illegible]
3. [illegible]
4. [illegible]
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95. [illegible]
96. [illegible]
97. [illegible]
98. [illegible]
99. [illegible]
100. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

03181		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03176		
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M	
ABIGAIL		L.	HENDER	SHOT	MARCH 3, 1969		8:50P	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
FEMALE	WHITE		9-8-1883		85	YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Mo.
MARYLAND		U. S. A.				ALLEGANY		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and no.)		12a. USUAL OCCUPATION (Kind of work done during last year, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND		MEMORIAL HOSPITAL		HOUSEWIFE				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
PENNA.		BEDFORD		BUFFALO MILLS				RT. 1
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last						
FRED STRUCKMAN		MALINDA HARTSOCK						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No		220-10-163		MEMORIAL HOSPITAL, CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Art. C. V. D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sensitiz</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5-6 days years years								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>2/25/69</u> , 19 <u>69</u> , to <u>3/3</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/3</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Thomas F. Lusby MD</u>		22c. DATE SIGNED <u>3/4/69</u>		22d. PHYSICIAN'S NAME (Type) DR. THOMAS F. LUSBY				
				22e. ADDRESS LAVALE, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		March 6, 1969		Madley Cemetery		Buffalo Mills, Pa. RD#1		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Harvey H. Zeigler, Hyndman, Pa.				DATE MAR 10 1969		<u>Charles Judge</u>		

03182

ORIGINAL L. HENRICHOT

MARCH 3, 1969

FEMALE

WHITE

9-2-1933

CO

MARYLAND

U. S. A.

X

ALLEGANY

CUMBERLAND

MEMORIAL HOSPITAL HOSPITALE

PENNA.

DEPTON BUFFALO WILLS

X

RT. 1

FRED

STUCKMAN

MALINDA

HARTSOCK

MEMORIAL HOSPITAL, CUMBERLAND, MD.

DR. THOMAS F. LUBY

LAVALLE, MD.

MAR 10 1969

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1/69

03182		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03177								
1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month Day Year		2b. HOUR			
LAMBERT		HENDERSON			MARCH 9, 1969		6:55 ^a M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH FEBRUARY 7, 1886		6. AGE (In years last birthday) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) MISSOURI		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY			Md.	
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL, CUMBERLAND, MD.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. VA.		13b. COUNTY Morgan		13c. CITY OR TOWN PAW PAW		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER c/o Postmaster		
14. FATHER'S NAME First Middle Lost JOSEPH HENDERSON		15. MOTHER'S MAIDEN NAME First Middle Lost MABEL HAYDEN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 236-68-4351A		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD. Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 433.9 IMMEDIATE CAUSE (a) cerebrovascular accident - thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) atherosclerotic vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs Years.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 3/8, 1969, to 3/9, 1969, that (I) (we) lost saw the deceased alive on 3/8/69 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE [Signature] MD		22c. DATE SIGNED 3/9/69		22d. PHYSICIAN'S NAME (Type) DR. SIMONS						
22e. ADDRESS CUMBERLAND, MARYLAND										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Mar. 11, 1969		23c. NAME OF CEMETERY OR CREMATORY St. Marys		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.				
24. FUNERAL DIRECTOR [Signature]		ADDRESS Johnson Funeral Home, Berkeley Springs, W. Va.		25a. REC. REG. TR. DATE MAR 13 1969		25b. REC. REG. TR. SIGNATURE [Signature]				

11180

RECEIVED
OFFICE OF THE
DIRECTOR

08180

DATE: 1941, 2

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

REFERENCE: [Illegible]

ENCLOSURE: [Illegible]

ADMINISTRATIVE: [Illegible]

NOTES: [Illegible]

APPROVAL: [Illegible]

SIGNATURE: [Illegible]

DATE: [Illegible]

LOCATION: [Illegible]

STATUS: [Illegible]

REMARKS: [Illegible]

INITIALS: [Illegible]

CHARTERED, MAILING

DATE: 1941, 1

08180

RECEIVED

03183

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last VIRGINIA MAE HENRY			2a. DATE OF DEATH Month Day Year March 20, 1969		2b. HOUR 5:30 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH May 3, 1914		6. AGE (In years last birthday) 54 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Allegany Md.		
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 205 South St.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 205 South St.	
14. FATHER'S NAME First Middle Last Leroy Keller		15. MOTHER'S MAIDEN NAME First Middle Last Katie Barger			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Walter Henry Cumberland, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion.</u> 2509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetic - Anterior Left Coronary Vessel Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>4-26</u> , 19 <u>55</u> , to <u>3-6</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/4/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>[Signature]</i>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/2/69	
22d. PHYSICIAN'S NAME (Type) G. Overton Hammond		22e. ADDRESS 133 W. Ave. Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/23/69	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Alleg., Md.	
24. FUNERAL DIRECTOR Philip B. Wendt 121 Memorial Ave., Cumb., Md.		25a. REC'D BY REGISTRAR MAR 24 1969		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0360

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																					
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																					
CERTIFICATE OF DEATH																					
03184																					
03179																					
1. DECEASED NAME (Type or print)			First RAYMOND			Middle EDWARD			Lost HERSHBERGER			2a. DATE OF DEATH 3 Month 20 Day 69 Year			2b. HOUR M						
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 04 28 98			6. AGE (In years not birthday) 70 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			IF UNDER 24 HRS. HOURS MIN.						
7a. BIRTHPLACE (State or foreign country) WEST VIRGINIA			7b. CITIZEN OF WHAT COUNTRY? UNITED STATES			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY			Md.									
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during the week preceding death) Seasonal Engineer			12b. KIND OF BUSINESS OR INDUSTRY Brewery												
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CUMBERLAND			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 50 N. MECHANIC STREET									
14. FATHER'S NAME First GEORGE			Middle HERSHBERGER			Lost (PENNER)			15. MOTHER'S MAIDEN NAME First Mattha			Middle Bennear			Lost RENEE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 214 05 4920			17. INFORMANT PATIENTS HOSPITAL CHART			Address 900 SETON DRIVE CUMBERLAND, MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 5192 DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC OBSTRUCTIVE LUNG DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) SMOKING DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DUODENAL ULCER										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State															
22a. I certify that (I) (this hospital) attended the deceased from 3-11, 19 69, to 3-20, 19 69, that (I) (we) last saw the deceased alive on 3-20, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE Dr. Matthew Kaufman			22c. DATE SIGNED 3-20-69								
22d. PHYSICIAN'S NAME (Type) DR. MATTHEW KAUFMAN			22e. ADDRESS 912 SETON DRIVE, CUMBERLAND, MD. 21502																		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 3/23/69			23c. NAME OF CEMETERY OR CREMATORY Zion Memorial Cemetery			23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.												
24. FUNERAL DIRECTOR H. Wayne George			Cumberland, Maryland			25a. REC'D BY REGISTRAR MAR 26 1969			25b. REGISTRAR'S SIGNATURE J. J. Judge												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1-69

<div>03185</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>03180</div>																											
1. DECEASED-NAME (Type or print)			First OSCAR			Middle W.			Last HOLLER			2a. DATE OF DEATH Month MARCH			Day 22			Year 1969			P.M. 10:30						
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 5 4-92			6. AGE (In years last birthday) 76			7. YRS.			IF UNDER 1 YEAR MONTHS			IF UNDER 24 HRS DAYS			IF UNDER 24 HRS HOURS			IF UNDER 24 HRS MIN.			
7a. BIRTHPLACE (State or foreign country) PENNA.			7b. CITIZEN OF WHAT COUNTRY? U.S.A			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY																		
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give full address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Pa. Dept. Hgys.			12b. KIND OF BUSINESS OR INDUSTRY State of Pa.																		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE PENNA.			13b. COUNTY BEDFORD			13c. CITY OR TOWN MANN'S CHO			13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			13e. STREET AND NUMBER RT. 1															
14. FATHER'S NAME First JOSEPH			Middle Last HOLLER			15. MOTHER'S MAIDEN NAME First ETTA			Middle Last SHEIRER																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no			16b. SOCIAL SECURITY NO. 190 28 1573			17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.																					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4109</u> <u>SARDIAL ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ALVTE ANTERIOR MYOCARDIAL INFARCT</u> <u>36 Hrs</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>COL. ARTERIOSCLEROSIS - COR/INSUFFICIENCY</u> <u>73-</u>																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 MIN									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>GENERALIZED ARTERIOSCLEROSIS, HIATAL HERNIA - ANEMIA</u>																											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)						21f. LOCATION Street or R.F.D. No. City or Town County State																		
22a. I certify that (I) (this hospital) attended the deceased from <u>3-20</u> , 19 <u>69</u> , to <u>3-22</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3-22</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																											
22b. SIGNATURE <u>Samuel Jacobson</u>																		DEGREE ATTENDING PHYS.			<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.			22c. DATE SIGNED 3-23-69			
22d. PHYSICIAN'S NAME (Type) DR. SAMUEL M. JACOBSON																		22e. ADDRESS CUMBERLAND, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 3-25-69			23c. NAME OF CEMETERY OR CREMATORY Schellsburg Cemetery			23d. LOCATION (City or Town) (County) (State) Schellsburg-Bedford- Pa.																		
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland																		25a. REC'D BY REGISTRAR DATE MAR 26 1969			25b. REGISTRAR'S SIGNATURE <u>William C. Jones</u>						

MEDICAL CERTIFICATION

03182

03180

CONTRACT NO. 100

THE UNITED STATES OF AMERICA

DATE: 12/1/50

TO: THE UNITED STATES OF AMERICA

FROM: THE UNITED STATES OF AMERICA

SUBJECT: THE UNITED STATES OF AMERICA

REFERENCE: THE UNITED STATES OF AMERICA

REMARKS: THE UNITED STATES OF AMERICA

APPROVED: THE UNITED STATES OF AMERICA

SIGNED: THE UNITED STATES OF AMERICA

WITNESSED: THE UNITED STATES OF AMERICA

ATTEST: THE UNITED STATES OF AMERICA

IN WITNESS WHEREOF, THE UNITED STATES OF AMERICA

DO hereby certify that the foregoing is a true and correct copy

of the original as the same appears in the files of the

Department of the Interior, Bureau of Land Management.

Very truly yours,

Director, Bureau of Land Management

U.S. DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WASHINGTON, D.C.

U.S. DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WASHINGTON, D.C.

U.S. DEPARTMENT OF THE INTERIOR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 14
45M

03186		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03181	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)		First		Middle		Last	
JOHN		A		HUGHES			
3. SEX		4. RACE		5. DATE OF BIRTH		2a. DATE OF DEATH	
MALE		BRUNEX WHITE		1-17-87		Month Day Year 3 9 69	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6. AGE (In years last birthday)	
W. VA.		U.S.A.				82 YRS.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND		MEMORIAL HOSPITAL		TEXTILE WORKER		JELANESE	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
MARYLAND		ALLEGANY		MT. SAVAGE		CHURCH HILL	
14. FATHER'S NAME		First		Middle		Last	
FRANCIS		P.		HUGHES			
15. MOTHER'S MAIDEN NAME		First		Middle		Last	
MARY				KILDOFF			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
NO		214-07-3211		MEMORIAL HOSPITAL		CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <i>Arteriosclerosis - Renal failure</i>							
DUE TO, OR AS A CONSEQUENCE OF (b) <i>hypertension - arteriosclerosis</i>							
DUE TO, OR AS A CONSEQUENCE OF (c) <i>diabetes mellitus</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
<i>Herpes Zoster - left Infarct - of Thalam by</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/5</u> , 19 <u>67</u> , to <u>3/9</u> , 19 <u>67</u> , that (I) (we) lost the deceased alive on <u>3/9</u> , 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
<i>S. G. Weisman</i>						3/12/69	
22d. PHYSICIAN'S NAME (Type)		DR. S. G. WEISMAN		22e. ADDRESS		CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL		MAR. 12, 1969		ST. PATRICK'S CEMETERY		MT. SAVAGE, MD.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
JOSEPH R. DURST, FROSTBURG, MD. 21632				MAR 18 1969		<i>Joseph R. Durst</i>	

03184

03184

OFFICE OF THE

JOHN A. HUGHES

TO: THE ATTORNEY GENERAL

FROM: THE ATTORNEY GENERAL

SUBJECT: THE ATTORNEY GENERAL

RE: THE ATTORNEY GENERAL

DATE: 1-11-42

BY: THE ATTORNEY GENERAL

FOR: THE ATTORNEY GENERAL

IN: THE ATTORNEY GENERAL

AT: THE ATTORNEY GENERAL

ON: THE ATTORNEY GENERAL

BY: THE ATTORNEY GENERAL

FOR: THE ATTORNEY GENERAL

IN: THE ATTORNEY GENERAL

AT: THE ATTORNEY GENERAL

ON: THE ATTORNEY GENERAL

BY: THE ATTORNEY GENERAL

FOR: THE ATTORNEY GENERAL

IN: THE ATTORNEY GENERAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03187

CERTIFICATE OF DEATH

03182

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR			
CLARENCE M. HURSH						MARCH 8 1969			4 A M			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS			
MALE		WHITE		OCT. 11, 1882			86 YRS.		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
PENNA		USA				ALLEGANY Md.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND			CUMBERLAND CONV. CENTER			SUPERVISOR			RAILROAD			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND			ALLEGANY						723 BEDFORD STREET			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
CHARLES					HURSH	MARY					MILLER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT					Address	
NO			717 07 5177A			MRS. CLAIRE HURSH					CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Paralysis Agitans</u> <u>342X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Uremia</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>10 yrs</u> <u>6 yrs</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>68</u> to <u>Mar 8</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Mar 6</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Clay E. Durrett</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>3/10/69</u>				
22d. PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT						22e. ADDRESS 236 VIRGINIA AVE. CUMBERLAND, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
BURIAL			MARCH 10, 1969		ST. PETER & PAUL CEM.			CUMBERLAND, MD.				
24. FUNERAL DIRECTOR BYRON KIGHT			ADDRESS CUMBERLAND, MD.			25a. REC'D BY REGISTRAR MAR 13 1969			25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			

03120

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 11-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03188

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH					
ANGELA			CECELIA	JACKSON	MARCH 20, 1969 7:50 P.M.						
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		WHITE		SEPT. 14, 1905		63 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.			
MARYLAND		U.S.A.				ALLEGANY					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
FROSTBURG			136 W. MAIN STREET			HOUSEWIFE			OWN HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
MARYLAND			ALLEGANY		FROSTBURG		X		136 W. MAIN STREET		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
WILLIAM			BAUER	FRANCES	GOODWIN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
NO			N.A.		NONE MR. THOMAS JACKSON, 136 W. MAIN ST., FROSTBURG, MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial Ischemia</u> 1719 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Rhabdomyosarcoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 8 mos.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Mar. 20, 1969</u> , to <u>Mar. 20, 1969</u> , that (I) (we) last saw the deceased alive on <u>Mar. 20, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS		22c. DATE SIGNED			
<u>Leslie R. Miles</u>			LESLIE R. MILES, M.D.			STATE STREET, LONACONING, MD.		3.22.69			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL			3/24/69		MT. SAVAGE CATH. CEM.		MT. SAVAGE, ALLEGANY, MD.				
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
MARILOU M. SOWERS, HAFFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG						MAR 27 1969		<u>Charles Judge</u>			

03182

ARMED AND DANGEROUS
MURDER
KIDNAPING
BOMBING
OBSTRUCTION OF JUSTICE
RECEIVED
JAN 10 1968

FRANK WHITE

U.S.A.

1000 N. MAIN STREET

WATKINS

STANLEY

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03189		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03184					
1. DECEASED-NAME (Type or print)		First NANNIE		Middle H.	Last JENKINS		2a. DATE OF DEATH Month 3 Day 2 Year 69		2b. HOUR 10:25 AM		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 7-6-1881		6. AGE (In years last birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 469 WILLIAMS ST.,			
14. FATHER'S NAME DENNIS		First Middle Last BEALL		15. MOTHER'S MAIDEN NAME MARY MC GEE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 214 05 6483B		17. INFORMANT MEMORIAL HOSPITAL-CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Acute Congestive Heart Failure</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 26</u> , 19 <u>69</u> , to <u>March 2</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>March 2</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE 		DEGREE ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 3-2-69						
22d. PHYSICIAN'S NAME (Type) G. Overton Himmelwright, M.D.		22e. ADDRESS 133 Virginia Ave., Cumberland, MD									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE MAR. 5, 1969		23c. NAME OF CEMETERY OR CREMATORY MT. PLEASANT CEMETERY		23d. LOCATION (City or Town) (County) (State) CUMBERLAND MD.					
24. FUNERAL DIRECTOR BYRON KIGHT		ADDRESS CUMBERLAND, MD.			25a. REC'D BY REGISTRAR MAR 6 1969		25b. REGISTRAR'S SIGNATURE 				

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31 JAN 1971

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E. J. 16537

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MEMORIAL HOSPITAL - CUMBERLAND, MD.

James M. Jones, President

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CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div>03190</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>03185</div>									
1. DECEASED-NAME (Type or print) Charles B. Johnston					2a. DATE OF DEATH at 10:40 P.M. Month March Day 20 Year 1969		2b. HOUR P.M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 2/2/1890		6. AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) W. Va.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany County Md.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Allegany County Infirmary		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired: Boiler		12b. KIND OF BUSINESS OR INDUSTRY B. & O.R.R.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 125 Polk Street	
14. FATHER'S NAME First Robert Middle Johnston Last Johnston			15. MOTHER'S MAIDEN NAME First Rebecca Middle Snyder Last Snyder						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 705-09-8687		17. INFORMANT P.O. Box 599, Cumberland, Md. Allegany County Infirmary records.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute respiratory failure DUE TO, OR AS A CONSEQUENCE OF Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute CVA. DUE TO, OR AS A CONSEQUENCE OF (c) approx. 1 hr. approx. 2 days.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from March 17, 1969 to March 20, 1969 , that (I) (we) last saw the deceased alive on March 20, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John A. Topper					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 3-21-69		
22d. PHYSICIAN'S NAME (Type) John A. Topper					22e. ADDRESS Memorial Hospital, Cumberland, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/24/69		23c. NAME OF CEMETERY OR CREMATORY Greenway Cemetery		23d. LOCATION (City or Town) (County) (State) Berkeley Springs W. Va			
24. FUNERAL DIRECTOR		ADDRESS 21502		25a. REC'D BY REGISTRAR March 26 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			
Silcox-Merritt Funeral Service, Cumberland, Md.									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03191

CERTIFICATE OF DEATH

03186

1. DECEASED NAME (Type or print) <i>Richard H. Jones</i>			2a. DATE OF DEATH <i>March</i> Month <i>16</i> Day <i>69</i> Year			2b. HOUR <i>9:30</i> M						
3. SEX <i>male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>3/16/84</i>		6. AGE (In years last birthday) <i>83</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <i>Kales</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Allegany</i> Md.						
10. CITY OR TOWN OF DEATH <i>Mt. Savage Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Columbia Ave</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Natural Gas Location</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>School</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Allegany</i>		13c. CITY OR TOWN <i>Mt. Savage</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Columbia Ave.</i>				
14. FATHER'S NAME First <i>Robert</i> Middle <i>Jones</i> Last <i>Jones</i>			15. MOTHER'S MAIDEN NAME First <i>Mary Ann</i> Middle <i>Prior</i> Last <i>Prior</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>			16b. SOCIAL SECURITY NO. <i>—</i>			17. INFORMANT <i>Mrs. Dorothy Witte</i>			Address <i>Mt. Savage Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary artery disease</i> (c) <i>Coronary artery disease</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>20 yrs</i> <i>20 yrs.</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Generalized arteriosclerosis-advanced age.</i>												
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>None</i>							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State <i>None</i>							
22a. I certify that (I) (this hospital) attended the deceased from <i>March 4, 1955</i> , to <i>Mar. 16, 1969</i> , that (I) (we) last saw the deceased alive on <i>March 16, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>James P. Hallinan M.D.</i>					DEGREE <i>M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. DATE SIGNED <i>3-17-69</i>												
22d. PHYSICIAN'S NAME (Type) <i>James P. Hallinan M.D.</i>					22e. ADDRESS <i>140 Bedford St., Cumberland, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3/19/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Sgt. Patuch's Cem.</i>			23d. LOCATION (City or Town) (County) (State) <i>Mt. Savage Allegany Md.</i>					
24. FUNERAL DIRECTOR <i>Louis Stein Inc. Cumb. Md.</i>					ADDRESS		25a. REC'D BY REGISTRAR DATE <i>MAR 19 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Wanda Page</i>			

TO THE SECRETARY OF THE INTERIOR
FROM THE DIRECTOR OF THE BUREAU OF LAND MANAGEMENT
SUBJECT: [Illegible]

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report containing several paragraphs of text, possibly discussing land management issues. Key words that are faintly visible include "Bureau of Land Management", "Department of the Interior", and "Secretary".]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03192		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03187	
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR A M
MARY		Letticia		KAHL	MARCH 8, 1969		4:35
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH APRIL 18, 1882		6. AGE (In years last birthday) 86 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Edward FRIEND		15. MOTHER'S MAIDEN NAME First Middle Last Rebecca JENKINS		13e. STREET AND NUMBER 625 COLUMBIA AVENUE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uræmia</u> 428X DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Influenza</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks 2 mos 2 wks							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 26, 1969</u> to <u>March 8, 1969</u> , that (I) (we) last saw the deceased alive on <u>March 8, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Clay Durrett</u>		22c. PHYSICIAN'S NAME (Type) DR. C. DURRETT		22d. ADDRESS 236 VIRGINIA AVE., CUMBERLAND, MD.		22e. DATE SIGNED 3/8/69	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/11/69		23c. NAME OF CEMETERY OR CREMATORY Zion Luth. Ch. Cem.		23d. LOCATION (City or Town) (County) (State) Accident, Garrett, Md.	
24. FUNERAL DIRECTOR <u>Kurt Newman</u>		ADDRESS Grantsville, Md.		25a. REC'D BY REGISTRAR DATE MAR 12 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

03139

DATE

APR 15, 1964

TIME

10:10 AM

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VA A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
03193					CERTIFICATE OF DEATH					03188		
1. DECEASED-NAME (Type or print)			First JOSEPH		Middle W		Last KIDWELL		2a. DATE OF DEATH Month Day Year MARCH 25 1969			2b. HOUR 7:20 PM
3. SEX MALE		4. RACE WHITE			5. DATE OF BIRTH 9-10-82			6. AGE (In years last birthday) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) PAW PAW, W. VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY						
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Boilermaker			12b. KIND OF BUSINESS OR INDUSTRY Railroad			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 112 1/2 ARCH ST.,			
14. FATHER'S NAME First Middle Last GEORGE W. KIDWELL			15. MOTHER'S MAIDEN NAME First Middle Last JULIA FLANE									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) no			16b. SOCIAL SECURITY NO. 220-10-2452		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Massive Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Atherosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 5 yrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on March 25, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Clay E. Durrett			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/26/69				
22d. PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT			22e. ADDRESS 236 VIRGINIA AVE., CUMBERLAND, MD.									
23a. BURIAL, CREMATION, or other disposition (Specify) Burial			23b. DATE Mar. 28, 1969		23c. NAME OF CEMETERY OR CREMATORY Woodrow Cemetery		23d. LOCATION (City or Town) (County) (State) Paw Paw, W. Va.					
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.						25a. REC'D BY REGISTRAR DATE APR 1 1969		25b. REGISTRAR'S SIGNATURE J. Charles Jones				

MEDICAL CERTIFICATION

08133

CERTIFICATE OF DEATH

08133

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MARCH 25 1969 7:50

KIDWELL

W

JOSEPH

08

9-10-62

WHITE

MALE

ALLIANCE

X

USA

PAV. BAY, VA.

MEMORIAL HOSPITAL

CUMBERLAND, MD.

112 ARCH ST.

CUMBERLAND, MD.

ALLIANCE

MD.

PLANE

JULIA

KIDWELL

GEORGE W.

250 - 10-62 MEMORIAL HOSPITAL, CUMBERLAND, MD.

DR. CLAY E. BURRETT

236 VIRGINIA AVE., CUMBERLAND, MD.

PAV. BAY, VA.

ALLIANCE

ALLIANCE, CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03194										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03189																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First CORA Middle RACHEL Last KING										3 Month 8 Day 69 Year										6:05 P M																																							
3. SEX FEMALE										4. RACE WHITE										5. DATE OF BIRTH 07/14/85										6. AGE (In years last birthday) 85 YRS.										IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.																			
7a. BIRTHPLACE (State or foreign country) W. Va.										7b. CITIZEN OF WHAT COUNTRY? USA										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH ALLEGANY Md.																													
10. CITY OR TOWN OF DEATH CUMBERLAND										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Cook,										12b. KIND OF BUSINESS OR INDUSTRY Restaurant																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.										13b. COUNTY ALLEGANY										13c. CITY OR TOWN Cumberland,										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 601 N. CENTRE STREET																			
14. FATHER'S NAME First FRANK Middle DUNN Last										15. MOTHER'S MAIDEN NAME First MARTHA Middle SHORT Last DUNN										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)										16b. SOCIAL SECURITY NO. 214 05 7261										17. INFORMANT SACRED HEART HOSPITAL Address 900 SETON DRIVE CUMBERLAND, MD.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4124 Atherosclerotic Cardio-vascular disease										DUE TO, OR AS A CONSEQUENCE OF (b)										DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 year																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus										19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from 3-4, 19 58, to 3-8, 19 69, that (I) (we) last saw the deceased alive on 3-8, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE R. W. Ballin										22c. DATE SIGNED 3-10-69										22d. PHYSICIAN'S NAME (Type) DR. R. W. BALLIN										22e. ADDRESS 62 GREENE STREET -CUMBERLAND, MD. 21502																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 3/11/69										23c. NAME OF CEMETERY DR CREMATORY Sunset Memorial Park,										23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.																													
24. FUNERAL DIRECTOR H. Wayne George										ADDRESS GEORGE FUNERAL HOME -202 GREENE ST. -CUMB., MD.										25a. REC'D BY REGISTRAR DATE 14 1969										25b. REGISTRAR'S SIGNATURE Charles Judge																													

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03195										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03190																																																	
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																																	
First MATILDA										Middle JANE										Last KIRBY										Month MARCH										Day 29										Year 1969										2b. HOUR 2 P M									
3. SEX FEMALE										4. RACE WHITE										5. DATE OF BIRTH JUNE 28, 1888										6. AGE (In years last birthday) 80										IF UNDER 1 YEAR MONTHS 80 YRS.										IF UNDER 24 HRS. HOURS 80 MIN.																			
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH ALLEGANY										Md.																													
10. CITY OR TOWN OF DEATH FROSTBURG										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MINERS HOSPITAL										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE										12b. KIND OF BUSINESS OR INDUSTRY																																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND										13b. COUNTY ALLEGANY										13c. CITY OR TOWN MT. SAVAGE										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER																													
14. FATHER'S NAME First THOMAS										Middle FRANKENBERRY										Last DOROTHY										15. MOTHER'S MAIDEN NAME First DOROTHY										Middle MILLER										Last																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)										16b. SOCIAL SECURITY NO.										17. INFORMANT MRS. MABEL ELLIOTT, FROSTBURG, MD. 21532										Address																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVD - c decompensation 4122 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a): stating the underlying cause last. (b) HEURP DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days - years -																																																											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																																					
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																																	
22a. I certify that (I) (this hospital) attended the deceased from march 15, 1969 , to march 29, 1969 . that (I) (was) last saw the deceased alive on 3/29 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.																																																																					
22b. SIGNATURE John B. Davis										DEGREE JOHN B. DAVIS, M. D.										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 3/31/69																																							
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS 2 BROADWAY, FROSTBURG, MD. 21532																																																											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL										23b. DATE APR. 1, 1969										23c. NAME OF CEMETERY OR CREMATORY METHODIST CEMETERY										23d. LOCATION (City or Town) (County) (State) MT. SAVAGE, MD.																																							
24. FUNERAL DIRECTOR JOSEPH R. DURST, FROSTBURG, MD. 21532										ADDRESS										25a. REC'D BY REGISTRAR APR 3 1969										25b. REGISTRAR'S SIGNATURE Charles Judge																																							

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 21 Film 410
3-26-69 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03196

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03191

1. DECEASED NAME (Type or Print) <u>Kathryn Catherine Henrietta Lamb</u>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <u>March 13, 1969</u> 3p M		2b. HOUR	
3. SEX <u>Female</u>	4. RACE <u>White</u>	5. DATE OF BIRTH <u>Sept. 23, 1913</u>	6. AGE (In years last birthday) <u>55</u> YRS.	IF UNDER 1 YEAR MONTHS _____ DAYS _____	IF UNDER 24 HRS. HOURS _____ MIN. _____
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <u>Cumberland</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>210 Frederick St.</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Unknown</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Allegany</u>		13c. CITY OR TOWN <u>Cumberland</u>	
14. FATHER'S NAME First <u>Asa</u> Middle _____ Lost _____		15. MOTHER'S MAIDEN NAME First <u>Anna</u> Middle _____ Lost <u>Kamp</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <u>313-14-2701</u>		17. INFORMANT ADDRESS <u>Aubra Beeghly LaVale, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Carbon Monoxide Poisoning</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Several Hours</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <u>3:00 P.M. March 11, 1969</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Carbon Monoxide from unvented heater.</u>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Home</u>		21f. LOCATION Street or R.F.D. No. City or Town County State <u>210 Frederick St. Cumberland Alleg. Md.</u>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>March 13, 1969</u>	
		ADDRESS (Street, city, town, or county) <u>Cumberland, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3/15/69</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Accident, Garrett, Maryland</u>	
24. FUNERAL DIRECTOR <u>Philip B. Wendt</u>		ADDRESS <u>121 Memorial Ave., Cumb., Md.</u>		25a. REC'D BY REGISTRAR DATE <u>17 1969</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

[Faint handwritten notes at the bottom of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03197

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03192

1. DECEASED-NAME (Type or print) First Middle Last LUCILLE T. LAMBERT			2a. DATE OF DEATH Month Day Year MARCH 11 1969		2b. HOUR M 7 P
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH JULY 3, 1892		6. AGE (In years last birthday) 76 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ALLEGANY Md.		
10. CITY OR TOWN OF DEATH FROSTBURG	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MINERS HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE WORK		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY ALLEGANY	13c. CITY OR TOWN FROSTBURG	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 72 W. MAIN STREET	
14. FATHER'S NAME First Middle Last WALTER A. TRIMBLE	15. MOTHER'S MAIDEN NAME First Middle Last MOLLIE FINDLEY				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address G. VICTOR LAMBERT, FROSTBURG, MD. 21532			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Stomach @ metast.</u> <u>151.9</u> <u>Weeks</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), (b) _____ stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>69</u> , to <u>March 4</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/11</u> , 19 <u>69</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>John B. Davis</u>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>3/14/69</u>	
22d. PHYSICIAN'S NAME (Type) JOHN B. DAVIS, M. D.		22e. ADDRESS 2 BROADWAY, FROSTBURG, MD. 21532			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE MAR. 14, 1969	23c. NAME OF CEMETERY OR CREMATORY ZION UNITED CEMETERY		23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR ADDRESS JOSEPH R. DURST, SR., FROSTBURG, MD. 21532		25a. REC'D BY REGISTRAR MAR 18 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-103. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03198

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03193

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. OATE KNOWN <input checked="" type="checkbox"/> Month Day Year		2b. HOUR	
GEORGE		VINCENT		LAVIN				OF ESTI- DEATH MATED <input checked="" type="checkbox"/> MARCH 1, 1969		4 a M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. OATE PRONOUNCED DEAD MARCH 1, 1969	
MALE	WHITE	JAN. 29, 1907		62 YRS.						2d. HOUR 4 a M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.	
HOFFMAN, MD.		U.S.A.				ALLEGANY					
1d. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
CUMBERLAND		MEMORIAL HOSPITAL--DOA		CURING ROOM		KELLY TIRE					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND		ALLEGANY		FROSTBURG				FROSTBURG, MD.			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIEN NAME		First Middle Last	
MICHAEL		LAVIN		ROSEANN		FOLK					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT				STREET, FROSTBURG, MD.			
NO		216-07-9081		MRS. G. VINCENT LAVIN		104 MT. PLEASANT					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS, LEFT 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN -----											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONITION FOR WHICH OPERATION WAS PERFORMED?				2d. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> MARCH 1, 1969			
ADDRESS (Street, city, town, or CUMBERLAND, MARYLAND											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		3/3/69		ST. MICHAELS CEMETERY		FROSTBURG, ALLEGANY, MD.					
24. FUNERAL DIRECTOR MARILOU M. SOWERS				25a. REC'D BY REGISTRAR DATE MAR 4 1969				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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POSTUM

DATE 10/25/1965 TIME 12:00 PM

• A. S. W. •

AD-241201

CONFIDENTIAL - SECURITY INFORMATION

RECEIVED 11/11/54

FOR STATE
HEALTH DEPT.

03199

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03194

1. DECEASED-NAME (Type or Print) Gertrude			First Middle Last W. Lebby			2a. DATE KNOWN OF DEATH ESTIMATED March 24, 1969			2b. HOUR 3:45p M		
3. SEX Female	4. RACE White	5. DATE OF BIRTH 2/6/1916	6. AGE (In years last birthday) 53 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD March 24, 1969			2d. HOUR 3:45p M		
7a. BIRTHPLACE (State or foreign country) Penna		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany			Md.		
10. CITY OR TOWN OF DEATH Allegany			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BEDFORD HOSPITAL--DOA			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Penna			13b. COUNTY Bedford		13c. CITY OR TOWN Hyndman	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RD#2			
14. FATHER'S NAME First Middle Last Otto Keidel			15. MOTHER'S MAIDEN NAME First Middle Last Wilhelmina Reninger								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, enter unknown) No			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Dr. D.W. Lebby, Hyndman, Pa. RD#1						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE FATTY LIVER 571.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Alcohol DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24-48 hours 3-4 days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Benedict Skitarelic			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 24, 1969			ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/27/69		23c. NAME OF CEMETERY OR CREMATORY Hyndman Cemetery			23d. LOCATION (City or Town) Hyndman, Bedford C., Pa.		County		State
24. FUNERAL DIRECTOR Harvey H. Zeigler, Hyndman, Pa.						25a. REC'D BY REGISTRAR APR 1 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03133

MEDICAL EXAMINER'S REPORT

INFORMED BY THE MEDICAL EXAMINER

03133

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03200

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03195

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First EDNA			Middle D.			Last LEE			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year MARCH 24 1969			2b. HOUR 12:01 A		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH APRIL 5, 1883		6. AGE (In years last birthday) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year MARCH 24, 1969			2d. HOUR 12:01 A		
7a. BIRTHPLACE (State or foreign country) W. VA.			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY			Md.					
10. CITY OR TOWN OF DEATH CUMBERLAND				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE WIFE				12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND				13b. COUNTY ALLEGANY				13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 143 MAPLE STREET					
14. FATHER'S NAME First Middle Last NELSON DUCKWORTH			15. MOTHER'S MAIDEN NAME First Middle Last MARY YONKER														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 213-22-3346				17. INFORMANT ADDRESS JENNIE LEE, 143 MAPLE ST., FROSTBURG, MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS, LEFT 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), storing the underlying cause last. } (b) CORONARY SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) ---														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL EXAMINER'S SIGNATURE Benedict Skitarelic				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED					
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				MARCH 24, 1969					
								ADDRESS (Street, city, town, County, State) CUMBERLAND, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE MAR. 26, 1969				23c. NAME OF CEMETERY OR CREMATORY F.B.G. MEMORIAL PARK				23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.					
24. FUNERAL DIRECTOR ADDRESS JOSEPH R. DURST, FROSTBURG, MD. 21532								25a. REC'D BY REGISTRAR DATE MAR 26 1969				25b. REGISTRAR'S SIGNATURE Charles Judge					

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03201									
CERTIFICATE OF DEATH									
03196									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
ANN			D. LIVINGSTON			3 Month 4 Day 69 Year			5:40 M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR
FEMALE		WHITE		12/7/71			97 YRS.		MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
NORTH CAROLINA		USA					ALLEGANY Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND			SACRED HEART HOSPITAL			HOUSEWIFE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MARYLAND			ALLEGANY			CUMBERLAND		13e. STREET AND NUMBER	
								49 GREENE STREET	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
ELISHA BROOKSHIRE			MARY KIRK						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address
NO			212 54 7848			HOSPITAL RECORDS			900 SETON DRIVE CUMBERLAND, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Cerebro-Vascular Accident									
4369 DUE TO, OR AS A CONSEQUENCE OF									
ARTERIOSCLEROSIS									
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 3 - 3, 19 69, to 3 - 4, 19 69, that (I) (we) last saw the deceased alive on 3 - 4 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					22c. DATE SIGNED				
Rough to Bruce M.D.					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			3-4-69	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
DR. R. W. BALLIN					62 GREENE STREET -CUMBERLAND, MD. 21502				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
BURIAL		MARCH 7, 1969		HILLCREST BURIAL PARK			CUMBERLAND ALLEGANY MD.		
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
SILCOX FUNERAL HOME					404 DECATUR -CUMB.,MD.		MAR 6 1969		

ROSEN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>03202</div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> </div> <div>03197</div>										
1. DECEASED-NAME (Type or print) BABY GIRL LLEWELLYN					2a. DATE OF DEATH Month 03 Day 13 Year 69			2b. HOUR 2:35A		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 03-12-69		6. AGE (In years lost birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS 12 8		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.				
10. CITY OR TOWN OF DEATH CUMBERLAND,			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NONE		12b. KIND OF BUSINESS OR INDUSTRY NONE		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN LONA CONING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER BOX 132, JACOBSON MT.	
14. FATHER'S NAME First THOMAS Middle LLEWELLYN Last LLEWELLYN			15. MOTHER'S MAIDEN NAME First SANDI Middle G. Last WILSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> NO (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. NONE		17. INFORMANT Address HOSPITAL RECORD, 900 SETON DR., CUMBERLAND, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 7769 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia + Atelectasis DUE TO, OR AS A CONSEQUENCE OF (c) + pneumothorax									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Robert D. Brodell M.D.					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) ROBERT D. BRODELL M.D.					22e. ADDRESS 500 GREENE ST., CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/14/69		23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION (City or Town) (County) (State) Moscow A. Md				
24. FUNERAL DIRECTOR George Eichhorn				ADDRESS Lonaconing, Md.		25a. REC'D BY REGISTRAR MAR 17 1969		25b. REGISTRAR'S SIGNATURE <i>William A. Younger</i>		

03509

03519

BABY	GIRL	LEVELLYN	03 13 00 2:30A
FEMALE	WHITE	03-12-00	12 8
MARYLAND	USA	X ALLEGANY	
CUMBERLAND,	SACRED HEART HOSPITAL	NONE	NONE
MARYLAND	ALLEGANY LONGACONING	X	BOX 132, JACKSON MT.
THOMAS	LEVELLYN	2ND1	G. WILSON
NO	NONE	HOSPITAL RECORD, 200 SETON DR., CUMBERLAND, MD	

ROBERT D. BRODELL F.B.I. 500 GREENE ST., CUMBERLAND, MD. 21502

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

03203

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03198

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) GRACE			First M.	Middle LOY	Last	2a. DATE OF DEATH Month 03 Day 05 Year 69			2b. HOUR 10:53		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 04-05-86			6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY COUNTY, Md.				
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY OWN HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 622 FREDERICK STREET		
14. FATHER'S NAME First CHARLES			Middle SIBLEY		Last (DIEHL) MINNIE			15. MOTHER'S MAIDEN NAME First SIBLEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 216 07 9644		17. INFORMANT Address MD. 21502 SACRED HEART HOSPITAL, 900 SETON DR., CUMB.,						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4319 IMMEDIATE CAUSE (a) CEREBRAL HEMMORHAGE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSION, SEVERE DUE TO, OR AS A CONSEQUENCE OF (c) CEREBRAL ARTERIOSCLEROSIS										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY 1 YR.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) GENERALIZED ARTERIOSCLEROSIS AND OSTEOARTHRITIS											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) NONE					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) NONE			21f. LOCATION Street or R.F.D. No. City or Town County State JULY 8, 68 MAR. 5, 69					
22a. I certify that (I) (this hospital) attended the deceased from MARCH 5, 1969 , to MAR. 5, 1969 , that (I) (we) last saw the deceased alive on 10:45 P.M. , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>J.P. Hallinan M.D.</i>						DEGREE # ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-6-69			
22d. PHYSICIAN'S NAME (Type) J.P. HALLINAN, M.D.						22e. ADDRESS 140 BEDFORD ST., CUMB., MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 3/8/1969		23c. NAME OF CEMETERY OR CREMATORY HILLCREST BURIAL PARK			23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.			
24. FUNERAL DIRECTOR KIGHT FUNERAL HOME, 309 DECATUR ST., CUMB., MD.						25a. REC'D BY REGISTRAR MAR 13 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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FROM

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34111

2-784

J. F. HOLLAND, JR.

140 BEDFORD ST., CORN., NO. 51205

KIGHT FUNERAL HOME, 309 DECATUR ST., CONN.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03204										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03199																													
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																													
GRACE H. MACBETH										3 Month 10 Day 69 Year										9:03 M																													
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.																																		
FEMALE			WHITE			1-5-90			79 YRS.			MONTHS			DAYS																																		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																																								
MD.			US OF A						ALLEGANY																																								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY																																								
CUMBERLAND			SACRED HEART HOSPITAL			Housewife																																											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER																																					
MD.			ALLEGANY			LA VALE			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			267 NATIONAL HWY.																																					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																																														
JOHN E.			MACBETH			(SOWERS) ADA			V.			MACBETH																																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address																																								
NO			220-07-6249			HOSPITAL RECORDS			900 SETON DR. CUMBERLAND, MD.																																								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
PART 1. DEATH WAS CAUSED BY:																																																	
IMMEDIATE CAUSE (a) <u>Carcinomatosis</u>										5																																							
1459 DUE TO, OR AS A CONSEQUENCE OF																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																																																	
(b) <u>Squamous cell cancer of mouth</u>										2 years																																							
DUE TO, OR AS A CONSEQUENCE OF																																																	
(c)																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
																				YES <input type="checkbox"/> NO <input type="checkbox"/>																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
										HOUR A.M. Month Day Year P.M. 19																																							
21d. INJURY OCCURRED										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION																													
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work																				Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from April, 1968, to 108th, 1969, that (I) (we) last saw the deceased alive on 108th, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																	
22b. SIGNATURE										DEGREE										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED																			
																														108th 1969																			
22d. PHYSICIAN'S NAME (Type)										F. W. MILTENBERGER, MD										22e. ADDRESS										122 S. CENTRE ST., CUMBERLAND, MD.																			
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																			
Burial										2/13/69										Rose Hill Cem.										Cumberland Allegany MD																			
24. FUNERAL DIRECTOR										Louis Stein Inc										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
										STEIN FUNERAL HOME										117 FREDERICK ST.										DATE										MAR 13 1969									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03205 Item #6, Film G411 4/7/69 km					03200				
1. DECEASED-NAME (Type or print) First Middle Last WILLIAM L. MARTZ					2a. DATE OF DEATH Month Day Year MARCH 28, 1969			2b. HOUR 10:10	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 1-4-1904		6. AGE (In years last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) TRUCK DRIVER			12b. KIND OF BUSINESS OR INDUSTRY CELANESE	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN LA VALE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 47 LA VALE BOULEVARD	
14. FATHER'S NAME First Middle Last NEWTON MARTZ				15. MOTHER'S MAIDEN NAME First Middle Last HATTIE SHAFFER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4109 IMMEDIATE CAUSE (a) <u>Pulmonary embolus.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Myocardial infarction</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>3/24</u> , 19 <u>69</u> , to <u>3/28</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/28</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>DR. G. M. SIMONS</u> MD DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/28/69		
22d. PHYSICIAN'S NAME (Type) DR. G. M. SIMONS					22e. ADDRESS CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 31, 1969		23c. NAME OF CEMETERY OR CREMATORY Restlawn Memorial Park		23d. LOCATION (City or Town) (County) (State) La Vale, Md. Allegany			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.					25. RECEIVED BY REGISTRAR APR 3 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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DR. C. W. SIMONIS

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Have Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03206

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03201

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month		Day		Year		2b. HOUR	
Marshall		R.		Mc		Elfish		ESTIMATED		Mar.		2		1969		6 A M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		Month		Day		Year	
Male	White	Jan. 15, 1890		79		YRS		MONTHS		DAYS		HOURS		MIN.		11 A M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Maryland		USA		WIDOWED		DIVORCED		Allegany		Cumberland		1006 Kentucky Ave.		Retired Millwright		Textile	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.	
Md.		Allegany		Cumberland		YES		1006 Kentucky Ave.		William		Hannah Robinette		yes		217-10-6465	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		19. DATE OF OPERATION		20. AUTOPSY?		21. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		22. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		23. LOCATION (City or Town) (County) (State)	
CORONARY OCCLUSION		SUDDEN		4109		DUE TO, OR AS A CONSEQUENCE OF		CORONARY SCLEROSIS		YES		NO		21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year	
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST.		DUE TO, OR AS A CONSEQUENCE OF		CORONARY SCLEROSIS		*****		HOUR A.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION (City or Town) (County) (State)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		DUE TO, OR AS A CONSEQUENCE OF		CORONARY SCLEROSIS		*****		P.M.		21g. LOCATION (City or Town) (County) (State)		21h. LOCATION (City or Town) (County) (State)		21i. LOCATION (City or Town) (County) (State)		21j. LOCATION (City or Town) (County) (State)	
22a. I certify that I took charge of the remains described above, held on death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner		22b. DATE SIGNED		22c. DATE SIGNED		22d. DATE SIGNED	
Actual Signature		Benedict Skitarelic		M.D.		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		March 2, 1969		March 2, 1969		March 2, 1969	
EXAMINER'S NAME (Type)		Dr. Benedict Skitarelic, M.D.		ADDRESS (Street, city, town, or county)		Rt. 9, Cumberland, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		23e. LOCATION (City or Town) (County) (State)	
Burial		March 5, 1969		St. Mary's Cemetery		Cumberland, Allegany, Md.		24. FUNERAL DIRECTOR		25. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE	
James F. Scarpelli, Cumberland, Md.		MAR 6 1969		Charles J. J...		Charles J. J...		Charles J. J...		Charles J. J...		Charles J. J...		Charles J. J...		Charles J. J...	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
03207										
03202										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
SARAH			McKENZIE			MARCH 2 1969		M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
FEMALE		WHITE		APRIL 12, 1891		77 YRS.		IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
MARYLAND		U.S.A.				ALLEGANY				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
FROSTBURG		MINERS HOSPITAL		HOUSE WORK		OWN HOME				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
MARYLAND		GARRETT		FROSTBURG				RT. 2		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
JACOB			BAKER			MARGARET BITTNER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
			214-42-0052-JI		RICHARD McKENZIE, RT. 2,		FROSTBURG, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Cerebral Hemorrhage</u> 4122 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Hypertensive CVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs - 18 yrs.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
✓		✓			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		✓			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>AUG. 1962</u> , to <u>3-2, 1969</u> , that (I) (we) lost the deceased on <u>Nov 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Martin M. Rothstein</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>3-3-69</u>			
22d. PHYSICIAN'S NAME (Type) <u>MARTIN M. ROTHSTEIN</u> <u>LESTER MILLS, M. D.</u>					22e. ADDRESS <u>FROSTBURG</u> <u>LEONARD, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		MARCH 4, 1969		JOHNSONS CEMETERY		GARRETT COUNTY, MD.				
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
JOSEPH R. AURST, FROSTBURG, MD. 21532							MAR 6 1969		<u>Francis J. J...</u>	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03208

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03203

1. DECEASED-NAME (Type or Print)		First	Middle	Last	20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year		2b. HOUR
Mary Ann Meanyhan					March 13, 1969		9a M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	7c. DATE PRONOUNCED DEAD		2d. HOUR
Female	White	9/25/1915		53 YRS.	March 13, 1969		9a M
70. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Maryland		U S A				Allegany Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland		DOA* Memorial Hospital		Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Allegany		Cumberland		153 Polk Street	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.	
Bashor		Cross		Mary		Sines	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
William H. Meanyhan		153 Polk St. Cumberland		PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION		SUDDEN	
				(b) CORONARY SCLEROSIS		---	
				(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
		19 P.M.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		22b. DATE SIGNED			
Benedict Skitarelic		M.D.		March 13, 1969			
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER		ADDRESS (Street, city, town, or county)			
BENEDICT SKITARELIC, M.D.				CUMBERLAND, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		Mar 16, 1969		Sunset Memorial Park		Near Cumberland Alleg Md	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Charles E. Hafer		230 Balto Ave. Cumberland Md		MAR 17 1969		V. Charles Indar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151 (4)
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03209										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03204																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Middle Last										Month Day Year										11:30M																																							
JOHN FREDERICK MEYERS										03 31 69																																																	
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR MONTHS DAYS HOURS MIN										IF UNDER 24 HRS. HOURS MIN									
MALE										WHITE										07-13-11										57																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md.																			
MARYLAND										U.S.A.																				ALEGANY COUNTY,																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
CUMBERLAND										SACRED HEART HOSPITAL										PLANT GUARD										PAPER MILL																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER																			
MARYLAND										Allegheny										MIDLAND										YES <input type="checkbox"/> NO <input type="checkbox"/>										BOX 52, MIDLAND, MD.																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address									
First Middle Last										First Middle Last										NO										214-07-5292										SACRED HEART HOSPITAL, 900 SETON DR., CUMB.,										MD. 21502									
FREDERICK MEYERS										(MC GOWAN) MARY MEYERS																																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANURIA</u> ; DUE TO, OR AS A CONSEQUENCE OF (b) <u>BROCHOGENIC NEOPLASM LEFT LUNG</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ANEMIA; MULTIPLE HEPATIC METASTASIS</u>																																																											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>GASTROINTESTINAL BLEEDING; HYPOPROTEINEMIA;</u>																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
3/31/69																																																											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										22c. DATE SIGNED																																																	
Richard Schindler										4-2-69																																																	
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
R. SCHINDLER, M.D.										69 GREENE ST., CUMBERLAND, MD. 21502																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
Burial										4/3/69										St. Michaels Cemetery										Frostburg A. Md																													
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
EICHORN FUNERAL HOME - 8 E. MAIN ST., LONA CONING										MD. 21539										APR 7 1969										Charles Judge																													

08300

08300

JOHN FREDERICK MEYERS

02 31 89 11:30

HALE

WHITE

07-12-11

27

U.S.A.

LEGARY COUNTY,

CHURCHLAND

SACRED HEART HOSPITAL

PLANT GUARD

UPPER HILL

MEYERS

HIGHLAND

BOX 22, HIGHLAND, MO.

FREDERICK

MEYERS

(10 DOWN) MEYERS

MEYERS

214-07-200

SACRED HEART HOSPITAL, BOX 22, HIGHLAND, MO.

F. SCHINDLER, H.D.

20 GREENE ST., CHURCHLAND, MO. 64502

SCHINDLER FUNERAL HOME - E. MAIN ST., LOUISIANA APR 1 1989

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
03210 CERTIFICATE OF DEATH 03205																	
1. DECEASED-NAME (Type or print)			First HARRY			Middle E.			Last MILLER			2a. DATE OF DEATH 3 Month 22 Day 69 Year			2b. HOUR 8:00 M		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 9-9-09			6. AGE (In years lost birthday) 59 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) PENNA.			7b. CITIZEN OF WHAT COUNTRY? US OF A			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY Md.								
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) ELECTRICIAN			12b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED								
13a. USUAL RESIDENCE (Where deceased admission) STATE PENNA.			13b. COUNTY MEYERSDALE			13c. CITY OR TOWN MEYERSDALE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 125 MEYERS AVE.					
14. FATHER'S NAME First ALLIE			Middle MILLER			Last MILLER			15. MOTHER'S MAIDEN NAME First (HOOVER) BERTHA			Middle MILLER			Last MILLER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO. 163-14-2397			17. INFORMANT HOSPITAL RECORDS			Address 900 SETON DR. CUMBERLAND, MD.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Renal failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Bleeding, ruptured duodenal ulcer</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>post operative subtotal gastrectomy</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																	
19a. DATE OF OPERATION 3-16-69			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Bleeding ruptured duodenal ulcer</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (1) (this hospital) attended the deceased from 3-13-1969, to 3-22-1969, that (1) (we) lost saw the deceased alive on 3-21-1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>Earl R. Paul</i>			DEGREE ATTENDING PHYS.			<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 3-22-69								
22d. PHYSICIAN'S NAME (Type) EARL R. PAUL, MD			22e. ADDRESS 414 N. MECHANIC ; ST., CUMB., MD														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 3-25-69			23c. NAME OF CEMETERY OR CREMATORY Union Cem			23d. LOCATION (City or Town) (County) (State) Meysersdale Pa								
24. FUNERAL DIRECTOR <i>H. P. Konow</i>			ADDRESS Meysersdale			25a. REC'D BY REGISTRAR MAR 28 1969			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>								

01250

Y 20 11

DATE (MM/DD/YY) TIME

62-11-3397 HUSBAND

[illegible]

1997, 1998, 1999, 2000

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 5 & 6 Film 410 3/14/69 kk 03211												MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03211 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Item 16 Film 412 5/9/69 kk Item 8																			
1. DECEASED-NAME (Type or Print)						First Middle Last						2a. DATE KNOWN OF DEATH						2b. HOUR													
GEORGE						MORGAN						<input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year MARCH 6, 1969						11 ^a M													
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD						2d. HOUR													
MALE		WHITE		Nov. 14, 1921		47 YRS.		MONTHS		DAYS		March 6, 1969						2 p M													
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. COUNTY OF DEATH								Md.											
MARYLAND				U.S.A.								ALLEGANY																			
10. CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)						12b. KIND OF BUSINESS OR INDUSTRY													
R.F.D. FROSTBURG						R.F.D. 1, FROSTBURG, MD.						AIR FORCE						AIR FORCE													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						13b. COUNTY						13c. CITY OR TOWN						13e. STREET AND NUMBER													
MARYLAND						ALLEGANY						FROSTBURG						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						R.F.D. 1, FROSTBURG							
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME																									
First Middle Last						First Middle Last																									
WILLIAM						MORGAN						CARRIE SPEIR																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b. SOCIAL SECURITY NO.						17. INFORMANT																			
YES						214-12-3830						MRS. CARRIE MORGAN, R.F.D. 1, FROSTBURG, MD.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART I. DEATH WAS CAUSED BY:																		Minutes													
IMMEDIATE CAUSE (a)																		Extensive burns													
DUE TO, OR AS A CONSEQUENCE OF																		Conflagration of home													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																															
(b)																															
DUE TO, OR AS A CONSEQUENCE OF																															
(c)																															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																															
19a. DATE OF OPERATION												19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?									
																						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>												21b. TIME OF INJURY Month, Day, Year										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
												11 AM 3-6-69										Caught in house fire									
21d. INJURY OCCURRED												21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION Street or R.F.D. No. City or Town County State									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>												home										R#1 Frostburg, Allegany, Maryland									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																															
22b. DATE SIGNED																															
MARCH 6, 1969																															
22c. REGISTRAR'S SIGNATURE																															
J. C. Sowers																															
22d. REGISTRAR'S NAME (Type)																															
BENEDICT SKITARELIC, M.D.																															
23a. BURIAL, CREMATION, REMOVAL (Specify)												23b. DATE										23c. NAME OF CEMETERY OR CREMATORY									
BURIAL												3/10/69										ALLEGHENY CEM. & CREMATORY PITTSBURGH, PA.									
23d. LOCATION (City or Town) (County) (State)												23e. REC'D BY REGISTRAR										23f. REGISTRAR'S SIGNATURE									
MARILYN M. SOWERS, HAFFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG												MAR 11 1969										J. C. Sowers, Jr.									

118211

MARCH 6, 1960

MARCH 6, 1960

MARYLAND U.S.S.

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03212

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year			2b. HOUR OF ESTI-MATED DEATH <input type="checkbox"/> March 29, 1969 2:26aM		
Charles Franklin Mulkey											
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR
Male	White	July 6, 1924	44 YRS.					March 29, 1969			2:26aM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Tennessee		U. S. A.				Allegany Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			Sacred Heart Hospital			Associate Professor A C C College					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Allegany			Cumberland				730 Dale Avenue	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Marcus L. Mulkey			Mattie Walker								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
Yes			WW 2			412-20-1902			Mrs. Margaret Mulkey, 730 Dale Ave		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ATELECTASIS OF LUNGS BILATERAL										XX 24 Hours	
8160 DUE TO, OR AS A CONSEQUENCE OF										About	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Blood in bronchi										60 Hours	
(c) DUE TO, OR AS A CONSEQUENCE OF										60 Hours	
fractured ribs, bilateral										60 Hours	
Contusions of lungs, bilateral										60 Hours.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
				:30 P.M. March 26 1969				Driver of Automobile out of control			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
				Highway				Winchester Road, Cumberland, Allegany, Maryland			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				Benedict Skitarelic M.D.				22b. DATE SIGNED			
EXAMINER'S NAME (Type)				Benedict Skitarelic, M.D.				March 29, 1969			
								ADDRESS (Street, city, town, or county) Cumberland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		April 1, 1969		Chattanooga Memorial Park		Chattanooga - Hamilton-Tenn					
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
John J. Hafer, Jr.				230 Baltimore Ave				APR 1 1969			
				Cumberland, Md.							

RECEIVED 2 JANUARY 1979

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1X89

03213		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		03208	
1. DECEASED-NAME (Type or print) First Middle Last DOROTHY M. NEUBISER			2a. DATE OF DEATH Month Day Year MARCH 11 1969		2b. HOUR PM 6:25
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH 6-14-98		6. AGE (In years last birthday) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HOURS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) PENNA.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ALLEGANY		
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HWFE.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY ALLEGANY	13c. CITY OR TOWN CUMBERLAND	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 438 WALNUT ST.,
14. FATHER'S NAME First Middle Last NEVIN SHAFFER		15. MOTHER'S MAIDEN NAME First Middle Last MARGARET DUNN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 213 09 6431	17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4121 Multiple pulmonary emboli IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ Arteriosclerosis + Hypertension At Base DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 10 yrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1969		21d. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	
21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 1967, to _____, 1969, that (I) (we) last saw the deceased alive on _____, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>[Signature]</i>		22c. DATE SIGNED 3/12/69		22d. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN	
22e. ADDRESS 59 GREENE ST., CUMBERLAND, MD.		22f. ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/14/69		23c. NAME OF CEMETERY OR CREMATORY WELLERSBURG C EMETERY	
23d. LOCATION (City or Town) (County) (State) WELLERSBURG PA.		23e. REC'D BY REGISTRAR MAR 17 1969			
24. FUNERAL DIRECTOR BYRON KIGHT		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

08813

08813

EXTRACT OF DEATH

JORDYNY

M.

NEUBERGER

18-11-1901

WHITE

18-11-1901

18-11-1901

ALL-AM

USA

CO-OPERATION

CO-OPERATION

ALLEGEDLY

NEW

SHAFER

ARRIVED

TO

213 09 0431

213 09 0431

3/14/69

WILLERSBURG C. KIRSTEN

WILLERSBURG

DEON KIGHT

CUMMINS, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03214

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03209

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
CATHERINE		E.		PAXTON	Month Day Year MARCH 15, 1969		PM 40	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
FEMALE	WHITE		2-3-03		66 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
PENNA.		USA				ALLEGANY		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND		MEMORIAL HOSPITAL		HWF.		OWN HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
MD.		ALLEGANY		CUMBERLAND				404 YORK PLACE
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
First Middle Last		First Middle Last						
SQUIRE		SHIPLEY		MINNIE SHROYER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
				MEMORIAL HOSPITAL, CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Sclerosis Heart Disease</u> 4123 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
				21g. <u>Joseph G. G. G.</u>				
22a. I certify that (I) (this hospital) attended the deceased from <u>4/5/64</u> , 19 <u>64</u> , to <u>3/15/69</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>3/15/69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)				
<u>Dr. R. J. Williams</u>		3/17/69		DR. R. J. WILLIAMS				
22e. ADDRESS		22f. ADDRESS						
		122 S. CENTRE ST., CUMBERLAND, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		March 18, 1969		St. Mary's Cemetery		Cumberland, Allegany, Md.		
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
James F. Scarpelli, Cumberland, Md.		MAR 19 1969		<u>Charles J. G. G.</u>				

03814

CERTIFICATE OF DEATH

MARCH 1, 1963

PAXTON

CATHERINE E.

66

2-3-03

WHITE

FEMALE

ALLEGANY

X

USA

PERMANENT

WHITE

MEMORIAL HOSPITAL

CUMBERLAND

404 YORK PLACE

ALLEGANY CUMBERLAND X

NO.

SHROYER

MINUTE

SHIPLEY

SOUTHE

MEMORIAL HOSPITAL, CUMBERLAND, MD.

Arthur J. Williams

X

Arthur J. Williams

3/1/63

Arthur J. Williams

122 S. CENTRE ST., CUMBERLAND, MD.

DR. R. J. WILLIAMS

CUMBERLAND, ALLEGANY, MD.

MARCH 1, 1963

... ..

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1-69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03215									
03210									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) LEONARD			First E. Middle PITTS Last			2a. DATE OF DEATH 3 Month 30 Day 69 Year		2b. HOUR 8:55A M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 10/29/95		6. AGE (In years give birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) ENGLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.			
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, if deceased retired) B/S D RAILROAD		12b. KIND OF BUSINESS OR INDUSTRY RAILROAD			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 138 POLK STREET	
14. FATHER'S NAME First F. Middle W. Last PITTS			15. MOTHER'S MAIDEN NAME First BESSIE Middle PITTS Last			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) NO (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. 217 10 6803			17. INFORMANT PATIENTS HOSPITAL CHART			Address 900 SETON DRIVE CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Generalized visceral failure PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Senility-Generalized arteriosclerosis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? None		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) None					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) None		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from April 16, 1969 , to March 30, 1969 , that (I) (we) last saw the deceased alive on March 30, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE J. P. Hallinan M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. DATE SIGNED 3-30-69		22d. PHYSICIAN'S NAME (Type) J. P. HALLINAN, M.D.							
22e. ADDRESS 140 BEDFORD ST., CUMBERLAND, MD. 21502									
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		23b. DATE 4/1/69		23c. NAME OF SEMETERY OR CREMATORY St. Luke's Cem.		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany MD			
24. FUNERAL DIRECTOR STEIN'S FUNERAL HOME		ADDRESS 117 FREDERICK CUMB., MD.		25. REC'D BY REGISTRAR APR 3 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

18812

LEONARD

E.

PITTS

3

30

09

12:30

WIFE

WHITE

10330325

23

X

ALLEGANY

U.S.A.

COUNCIL NO. 10.

2/10/30 PATIENTS HOSPITAL

30 RAILROAD

RAILROAD

ALLEGANY

COUNCIL NO.

X

101 POLK STREET

F.

PITTS

(NY)

DESSIE

PITTS

10

217 10 303 PATIENTS HOSPITAL CHAIR

CUTLICK, NO. 1000 SECTION PRIVATE

STEIN'S FURNERAL HOME

CUTLICK, NO. 117 FREDERICK ST.

18812

140 BEDFORD ST., COUNCIL NO. 21502

J. P. HILL, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Items 1, 14 & 15 Film 410 3/13/69 kkk		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		03211	
03216		CERTIFICATE OF DEATH		03211	
1. DECEASED-NAME (Type or print) First Middle Last REGIS C. PONGIBOVE		2a. DATE OF DEATH 3 Month 2 Day 69 Year		2b. HOUR 11:25	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 08/22/42	
6. AGE (In years last birthday) 26 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH ALLEGANY		10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL	
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) TEACHER-ELK LICK JOINT HIGH SCHOOL		12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE PENNSYLVANIA	
13b. COUNTY ALLEGANY		13c. CITY OR TOWN PITTSBURGH		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 801 CHASKE STREET		14. FATHER'S NAME First Middle Last MARIO Pongibove PONGIBOVE		15. MOTHER'S MAIDEN NAME First Middle Last (HOWER) HAZEL Pongibove PONGIBOVE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 204 32 6397		17. INFORMANT PATIENT'S HOSPITAL CHART	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMOPERICARDIUM 441.0 DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), (b), OR (c) ACUTE DISSECTING AORTIC ROOT ANEURYSM DUE TO, OR AS A CONSEQUENCE OF TEAR IN AORTIC ROOT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	
21f. LOCATION Street or R.F.D. No. City or Town County State		22a. I certify that (I) (this hospital) attended the deceased from 3-1, 1969, to 3-2, 1969, that (I) (we) last saw the deceased alive on 3-2, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Matthew Kaufman DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. DATE SIGNED 3-3-69		22d. PHYSICIAN'S NAME (Type) MATTHEW KAUFMAN, M.D.		22e. ADDRESS 912 SETON DRIVE, CUMBERLAND, MD. 21002	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Mar. 7, 1969		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
23d. LOCATION (City or Town) (County) (State) Pittsburgh, Pa.		24. FUNERAL DIRECTOR Scarpelli Funeral Home, Cumberland MC CABE BROTHERS, PITTSBURGH, PENNSYLVANIA		25a. RECEIVED BY REGISTRAR MAR 6 1969 DATE	
25b. REGISTRAR'S SIGNATURE Charles J. J...					

05210

REGIS

C.

PONGEONE

3

2

02

11:25P

FILE

WHITE

02/22/42

ALLEGANY

X

PENNSYLVANIA U.S.A.

CUMBERLAND

SACRED HEART HOSPITAL

401 CHASKE STREET

PITTSBURGH

X

PENNSYLVANIA

WARD

PONGEONE

(HOWER) HAZEL

PONGEONE

204 22 2007 PATIENT'S HOSPITAL CHART

10

412 SETON DRIVE, CUMBERLAND, MD. 21502

WATKINS KNOX, I.D.

MC GEE BROTHERS, PITTSBURGH, PENNSYLVANIA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03217		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03212			
1. DECEASED-NAME (Type or print) First Middle Last RICHARD A. PUGH						2a. DATE OF DEATH MARCH Month 31 Day 1969 Year		2b. HOUR 1 P. M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH JANUARY 27, 1877		6. AGE (In years last birthday) 92 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.			
10. CITY OR TOWN OF DEATH FROSTBURG		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 195 Welsh Hill			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 195 WELSH HILL	
14. FATHER'S NAME First Middle Last RICHARD PUGH				15. MOTHER'S MAIDEN NAME First Middle Last ANN McGARY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO.		17. INFORMANT Address JAMES PUGH, 195 WELSH HILL, FROSTBURG, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arterio-sclerotic heart disease</u> 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Senility</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>3-29</u> , 19 <u>69</u> , to <u>3-31</u> , 19 <u>69</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>3-29</u> , 19 <u>69</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (<u>did</u>) (did not) view the body after death.									
22b. SIGNATURE <u>H. C. Diehl, M. D.</u>		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-1-69			
22d. PHYSICIAN'S NAME (Type) H. C. DIEHL, M. D.		22e. ADDRESS 39 W. MAIN ST., FROSTBURG, MD. 21532							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE APR. 2, 1969		23c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL'S CEMETERY		23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.			
24. FUNERAL DIRECTOR ADDRESS JOSEPH R. DURST, FROSTBURG, MD. 21532				25a. REC'D BY REGISTRAR DATE APR 7 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

03610

03610

DATE: 11/10/54

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

03218

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03213

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR	
Michael Quartucci					ESTIMATED <input checked="" type="checkbox"/> MARCH 22, 1969					11:20 M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		
Male	White	Mar. 3, 1884		85 YRS.	MONTHS DAYS		HOURS MIN.		Month Day Year		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Italy		USA				Allegany Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland		Sacred Heart Hospital			Retired-Cement Finisher						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Md.		Allegany		Cresaptown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		None			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
Nicholas Quartucci					Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
no				Nicholas Quartucci, Frostburg, Md. Son							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ANASARCA, GENERALIZED										24-36 Hours	
9502 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ACUTE DORIDEN POISONING										47 Hours	
(c) (Self Induced)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				BENEDICT SKITARELIC, M.D.				22b. DATE SIGNED			
								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 22, 1969			
								ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		3-25-1969		Sunset Memorial Park		Cumberland, Md. Allegany					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
James F. Scarpelli, Cumberland, Md.								MAR 26 1969		Charles Judge	

08318

MEDICAL COMMITTEE MEMORANDUM OF 1941

08318

1. NAME	2. GRADE	3. BRANCH	4. DATE
5. TITLE	6. DUTY	7. REPORT	8. COMMENTS
9. ACTION	10. RECOMMENDATION	11. APPROVAL	12. SIGNATURE
13. DATE	14. TIME	15. PLACE	16. OTHER
17. NAME	18. GRADE	19. BRANCH	20. DATE
21. TITLE	22. DUTY	23. REPORT	24. COMMENTS
25. ACTION	26. RECOMMENDATION	27. APPROVAL	28. SIGNATURE
29. DATE	30. TIME	31. PLACE	32. OTHER
33. NAME	34. GRADE	35. BRANCH	36. DATE
37. TITLE	38. DUTY	39. REPORT	40. COMMENTS
41. ACTION	42. RECOMMENDATION	43. APPROVAL	44. SIGNATURE
45. DATE	46. TIME	47. PLACE	48. OTHER
49. NAME	50. GRADE	51. BRANCH	52. DATE
53. TITLE	54. DUTY	55. REPORT	56. COMMENTS
57. ACTION	58. RECOMMENDATION	59. APPROVAL	60. SIGNATURE
61. DATE	62. TIME	63. PLACE	64. OTHER
65. NAME	66. GRADE	67. BRANCH	68. DATE
69. TITLE	70. DUTY	71. REPORT	72. COMMENTS
73. ACTION	74. RECOMMENDATION	75. APPROVAL	76. SIGNATURE
77. DATE	78. TIME	79. PLACE	80. OTHER
81. NAME	82. GRADE	83. BRANCH	84. DATE
85. TITLE	86. DUTY	87. REPORT	88. COMMENTS
89. ACTION	90. RECOMMENDATION	91. APPROVAL	92. SIGNATURE
93. DATE	94. TIME	95. PLACE	96. OTHER
97. NAME	98. GRADE	99. BRANCH	100. DATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03219

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03214

1. DECEASED-NAME (Type or print) Ruth			First M.	Middle Rank	Last	2a. DATE OF DEATH at 1:35 P.M.		2b. HOUR M		
					Month March Day 11 Year 1969					
3. SEX Female		4. RACE White		5. DATE OF BIRTH 5/11/1903		6. AGE (In years last birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7b. BIRTHPLACE (State or foreign country) W. Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany County Md.				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Allegany County Infirmary		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 319 Columbia Street		
14. FATHER'S NAME First Perry			Middle	Last Rinehard	15. MOTHER'S MAIDEN NAME First Mary			Middle	Last Buckalew	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. 220-10-4172D		17. INFORMANT P. O. Box 599, Allegany County Infirmary records.				Address Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute renal insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) Chronic A.F. DUE TO, OR AS A CONSEQUENCE OF (c) Chn. A.S.H.D. with hypertension C.H.F. many years CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few days many years										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Hepatomegaly, Cirrhosis, Gangrene Q 3rd toe										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Jan. 23, 1969 , to March 11, 1969 , that (I) (we) lost the deceased alive on March 10, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE John A. Topper M.D.				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED Mar 12 - 1969		
22d. PHYSICIAN'S NAME (Type) John A. Topper				22e. ADDRESS Memorial Hospital, Cumberland, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/14/1969		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Near Cumberland Alleg Md				
24. FUNERAL DIRECTOR John J. Harer, Jr.				ADDRESS 230 Balto Ave Cumberland Md		25a. REC'D BY REGISTRAR MAR 14 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

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1953, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849

207

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03220 CERTIFICATE OF DEATH 03215									
1. DECEASED-NAME (Type or print) Elizabeth Reitz			First Middle Last REITZ			2a. DATE OF DEATH Month Day Year March 7 1969		2b. HOUR P 7:25 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Jan. 19, 1890		6. AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 2 weeks	
7a. BIRTHPLACE (State or foreign country) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.			
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Miners Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 203 Fairfax St.	
14. FATHER'S NAME First Middle Last Joseph B. Louk			15. MOTHER'S MAIDEN NAME First Middle Last Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Nora Jenkins, Cumberland, Md. Niece				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 491X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic bronchitis DUE TO, OR AS A CONSEQUENCE OF (c) Asthma + Emphysema APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks years years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1963 to MAR. 7, 1969 , that (I) (we) last saw the deceased alive on MAR. 6, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Samuel J. Miles DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 3-9-69				
22d. PHYSICIAN'S NAME (Type) L.R. MILES, JR.					22e. ADDRESS LONA CONING MD. 21539				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 10, 1969		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR ADDRESS James F. Scarpelli, Cumberland, Md.					25a. REC'D BY REGISTRAR DATE MAR 11 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

03217

STATE OF OHIO

08280

IN SENATE,
January 17, 1900.
REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE,
IN RESPONSE TO A
RESOLUTION PASSED
BY THE SENATE,
MAY 1, 1899.
COLUMBUS, OHIO:
JANUARY 17, 1900.

THE LAND OFFICE
OF THE STATE OF OHIO
HAS THE HONOR TO
ACKNOWLEDGE THE
RECEIPT OF THE
REPORT OF THE
COMMISSIONER OF THE
LAND OFFICE,
IN RESPONSE TO A
RESOLUTION PASSED
BY THE SENATE,
MAY 1, 1899.
COLUMBUS, OHIO:
JANUARY 17, 1900.

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03221

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03216

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Martha Ellen Rice						Month Day Year			12:10 P M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			12:10 P M
Female	White	Oct. 3, 1882	86 YRS.	MONTHS	DAYS	HOURS	MIN.	Month 3 Day 11 Year 1969			P M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
West Virginia		USA				Allegany Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			D.O.A. Memorial H.			Housewife			Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Md.			Allegany		Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Rear 202 Springdale St.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Henry Turner			Martha Davis								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
no					Mrs. Mollie Oster, Cumberland, Md.-Daughter						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										CORONARY OCCLUSION	
4109 DUE TO, OR AS A CONSEQUENCE OF										SUDDEN	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										CORONARY SCLEROSIS	
(b) DUE TO, OR AS A CONSEQUENCE OF										----	
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. P.M.		19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED			
EXAMINER'S NAME (Type)		Dr. Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		March 11, 1969			
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Rt. 9, Cumberland			
						ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		3-15-1969		Sunset Memorial Park		Cumberland, Md. Allegany					
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James F. Scarpelli, Cumberland, Md.						DATE		MAP 17 1969			

1000

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 21 Film 410 3-26 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03217	
03222 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) First Middle Last LLOYD LEE ROACH						2a. DATE OF DEATH <input checked="" type="checkbox"/> EST. <input checked="" type="checkbox"/> MATED <input checked="" type="checkbox"/> Month Day Year March 11, 1969		2b. HOUR 3p M			
3. SEX Male	4. RACE White	5. DATE OF BIRTH 1/27/26	6. AGE (In years last birthday) 43 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year March 13, 1969		2d. HOUR 4p M			
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 210 Frederick St.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Construction				
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 210 Frederick St.			
14. FATHER'S NAME First Middle Last Piney Roach				15. MOTHER'S MAIDEN NAME First Middle Last Myrtle Short							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 229-20-9519		17. INFORMANT ADDRESS Piney Roach Gretna, Virginia							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Carbon Monoxide Poisoning (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several Hour											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR AM P.M. 3:00 P.M. March 11 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Carbon Monoxide from unvented heater.							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No. City or Town County State 210 Frederick St. Cumberland Alleg. Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) Benedict Skitarelic				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED March 13, 1969 ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/15/69		23c. NAME OF CEMETERY OR CREMATORY Gretna Burial Park		23d. LOCATION (City or Town) (County) (State) Gretna, Pittsylvania, Virginia					
24. FUNERAL DIRECTOR ADDRESS Philip B. Wendt 121 Memorial Ave., Cumb., Md.				25a. REC'D BY REGISTRAR DATE MAR 17 1969		25b. REGISTRAR'S SIGNATURE <i>Alvin S. Judge</i>					

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1003. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03223

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03218

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE OF DEATH			Month Day Year			2b. HOUR			
CLARA E. ROBINETTE						MARCH 15 1969			3 15 1969			6 A M			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD			2d. HOUR				
FEMALE	WHITE	AUG. 20, 1879	89 YRS					Month Day Year 3 15 1969			3 P M				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH						
MD.			USA						ALLEGANY Md.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY						
CUMBERLAND			523 WELSH AVENUE			HOUSEWIFE			OWN HOME						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER			
MARYLAND			ALLEGANY			CUMBERLAND						523 WELSH AVENUE			
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last						
PETER BRANT						LAURA STEIN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
NO			NONE			EDWARD E. ROBINETTE			CUMBERLAND, MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4109</u> <u>CORONARY OCCLUSION</u> DUE TO, OR AS A CONSEQUENCE OF <u>CORONARY SCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN ----			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town			County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Benedict Skitaralic</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED						
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			MARCH 15, 1969									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
BURIAL			MARCH 18, 1969			ZION MEMORIAL PARK			CUMBERLAND, MD.						
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
BYRON KIGHT			CUMBERLAND, MD.			MAR 18 1969			<u>[Signature]</u>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03224		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03219		
CERTIFICATE OF DEATH								
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		
WINIFRED			GRACE	ROBINETTE	MARCH		Month 31 Day 1969	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		
FEMALE		WHITE		10-8-1890		78 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
MARYLAND		USA				ALLEGANY Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND		MEMORIAL HOSPITAL		HOUSEWIFE				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
MARYLAND		ALLEGANY		FLINTSTONE		13e. STREET AND NUMBER ROUTE #2		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME		
ELI			WILSON	CHARLOTTE	V.	GROWDEN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT			
NO			216-38-1957		MEMORIAL HOSP. CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic Ca of Colon</u> 1538 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>months</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 28, 1969</u> , to <u>Mar 31, 1969</u> , that (I) (we) last saw the deceased alive on <u>Mar 31, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Blane Schindler</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4-1-69</u>		
22d. PHYSICIAN'S NAME (Type) BLANE SCHINDLER, M.D.				22e. ADDRESS 43 GREENE ST., CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		4/ 2/1969		Hillcrest Burial Park		Near Cumberland Alleg Md		
24. FUNERAL DIRECTOR <u>Charles E. Harer</u>				ADDRESS Charles E. Harer, 230 Balto Ave. Cumberland		25a. REC'D BY REGISTRAR APR 3 1969		
						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

03224

03210

DATE: 10-10-50 TIME: 10:10 AM

FROM: [illegible] TO: [illegible]

SUBJECT: [illegible]

RE: [illegible]

BY: [illegible]

FOR: [illegible]

THROUGH: [illegible]

BY AIR: [illegible]

BY SEA: [illegible]

BY RAIL: [illegible]

BY ROAD: [illegible]

BY OTHER: [illegible]

BY [illegible]: [illegible]

BY [illegible]: [illegible]

BY [illegible]: [illegible]

BY [illegible]: [illegible]

BY [illegible]: [illegible]

BY [illegible]: [illegible]

BY [illegible]: [illegible]

BY [illegible]: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03225					03220				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH				
First Middle Last CARRIE E ROBISON					Month Day Year 3 24 69				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		2b. HOUR	
FEMALE		WHITE		2-21-90		79 YRS.		10:25A	
7a. BIRTHPLACE (State or foreign country)		7b. COUNTRY OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		U.S.A.				ALLEGANY			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		MEMORIAL HOSPITAL		HOUSEWIFE					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		ALLEGANY		CUMBERLAND				12 BLACKISTON AVENUE	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
CHARLES SMITH			ATCY ATCY			DICKEN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO *181-18-8960*			181-18-8960		MEMORIAL HOSPITAL CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> 1 hr									
4419 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Artery Disease</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
				<i>4419 Allegany Md</i>					
22a. I certify that (I) (this hospital) attended the deceased from <i>4/3/69</i> , 19 <i>69</i> , to <i>3/24/69</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>3/24/69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Dr. R. J. Williams</i>				22c. DATE SIGNED <i>3/25/69</i>					
22d. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS				22e. ADDRESS CUMBERLAND, MD.					
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		3/27/1969		P O S of A Cemetery		Centerville Bedford Pa.			
24. FUNERAL DIRECTOR <i>John J. Hafer, Jr.</i>				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
John J. Hafer, Jr.				230 Balto Ave. Cumberland Md		MAR 27 1969			

03222

DEPARTMENT OF HEALTH

03222

CARRIE

E

ROBINSON

FEMALE

WHITE

3-21-20

MARYLAND

U.S.A.

X

ALLEGANY

CUMBERLAND

MEMORIAL HOSPITAL

HONORARY

MARYLAND

ALLEGANY

CUMBERLAND

X

12 CLACKSON AVENUE

CHARLES

SMITH

TOY

ALLEG

DICKER

MEMORIAL HOSPITAL 2101 - 1920

MEMORIAL HOSPITAL

CUMBERLAND, MO.

DR. R. J. WILLIAMS

CUMBERLAND, MO.

FOR A Cemetery

1920

1920

1920

John I. Nelson, 1st 230 Radio Ave. Cumberland, MO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be rec'd within 24 hours after death.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03226

03221

1. DECEASED NAME (Type or print) Mary First Ethel Middle Rogers Last			2a. DATE OF DEATH Mar. Month 16 Day 1969 Year			2b. HOUR 10 A M					
3. SEX Female		4. RACE White		5. DATE OF BIRTH Jan. 11, 1888		6. AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) W. Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.					
10. CITY OR TOWN OF DEATH Westernport			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 520 Md. Ave.			12a. USUAL OCCUPATION (Kind of work done during most of working life or if retired.) House wife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md			13b. COUNTY Allegany		13c. CITY OR TOWN Westernport		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 520 Md. Ave.		
14. FATHER'S NAME First William Middle G. Kalbaugh Last			15. MOTHER'S MAIDEN NAME First Amanda Middle Kight Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address William E. Rogers - Westernport, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 wks			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from February , 19 60 , to March 16 , 19 69 , that (I) (we) last saw the deceased alive on March 16 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Phillip G. Stagers, M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/17/69	
22d. PHYSICIAN'S NAME (Type) Phillip G. Stagers		22e. ADDRESS Keyser, W. Va.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3/19/69		23c. NAME OF CEMETERY OR CREMATORY Queens Point			23d. LOCATION (City or Town) (County) (State) Keyser Mineral W. Va.				
24. FUNERAL DIRECTOR E. J. Brual				ADDRESS Westernport, Md.				25a. REC'D BY REGISTRAR DATE MAR 20 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
03227											
03222											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR			
GEORGE			JOSEPH			Month 03 Day 24 Year 69			9:25A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years 86 birth day)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
MALE		WHITE		03-19-83		86		YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		USA				ALLEGANY Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
CUMBERLAND		SACRED HEART HOSPITAL		RETIRED Mgr.		Industrial Cafeteria					
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND		ALLEGANY		CUMBERLAND				408 KEAN TERR.			
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last		
VITUS			ROSSWORM			SUSAN			BRODIGAN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT				Address	
NO			214-07-5042			HOSPITAL RECORD, 900 SETON DR., CUMB., MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>cremia</u>										1 week	
DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>cardio-renal-vascular disease</u>										1 year	
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>arteriosclerosis</u>										2 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>3-20</u> , 19 <u>69</u> , to <u>3-24</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3-23</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED				22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. REGISTRAR'S SIGNATURE	
L. Brings MD		3-24-69				LEWIS BRINGS, M.D.		57 GREENE ST., CUMBERLAND, MD.		Charles Judge	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		23e. REGISTRAR'S SIGNATURE		23f. REGISTRAR'S SIGNATURE	
burial		3/27/69		SS. Peter & Paul Cem.		Cumberland, Allegany Md.					
24. FUNERAL DIRECTOR H. Wayne George						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
GEORGES FUNERAL HOME Cumberland, Maryland						DA APR 1 1969					

03383

MALE	WHITE	10-10-23	26	ALLEGANY	03 21 00 0:25
CLINICAL	BACKED HEART HOSPITAL	RETIRED			
ALLEGANY	ALLEGANY	CUMBERLAND	X	FOR KEAN TIRE	
VITUS	RESUME	SWAN			
21-07-23	HOSPITAL RECORD	2ND SETON DR. CUM...			

LEWIS BRINGS, H. O. 27 GREEN ST., CUMBERLAND, MD.

22. Peter & Paul...
George's Funeral Home...
Allegany...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>03228</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item 13 Film 411 4/2/69 kk</div> <div>CERTIFICATE OF DEATH</div> <div>03223</div>											
1. DECEASED-NAME (Type or print) First Middle Last Charlotte Izora Ruppert						2a. DATE OF DEATH March 20, 1969			2b. HOUR 7p. M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH June 29, 1882		6. AGE (In years lost birthday) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kinchen Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Cook		12b. KIND OF BUSINESS OR INDUSTRY Restaurant					
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Penn.		13b. COUNTY Hyndman		13c. CITY OR TOWN Pa.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First Middle Last James Cline		15. MOTHER'S MAIDEN NAME First Middle Last Mary Ellen Miller		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 216-22-7410		17. INFORMANT Address Mrs. Blanche Tipton, Hyndman, Pa. 15545			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4123</u> <u>Myocarditis & Desquamation</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocarditis & Desquamation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 mon</u> <u>5 yrs</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>Mar 15, 1968</u> to <u>Mar 20, 1969</u> , that (I) (we) last saw the deceased alive on <u>Mar 15, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Clay Durrett</u>		22c. DATE SIGNED 3/21/69		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (Type) Clay Durrett		22e. ADDRESS Cumberland, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 23, 1969		23c. NAME OF CEMETERY OR CREMATORY Hyndman Cemetery		23d. LOCATION (City or Town) (County) (State) Hyndman, Bedford Co., Pa.					
24. FUNERAL DIRECTOR Harvey H. Zeigler, Hyndman, Pa.		25a. REC'D BY REGISTRAR DATE MAR 24 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15-44
45M - 11-69

03229		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03224	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH		2b. HOUR
PHILOMENA		F.	SANTESANIO		Month	Day	Year
03		26		69	10:00		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS
FEMALE	WHITE		01-26-01		68 YRS.		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
ITALY	USA				ALLEGANY COUNTY, Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during month even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND		SACRED HEART HOSPITAL		HOUSEWIFE		OWN HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MARYLAND		ALLEGANY		CUMBERLAND		13e. STREET AND NUMBER	
						131 HANOVER STREET	
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First Middle Lost
PETE		SANSIVIERO			(CINESCIO) CARMEL		SANSIVIERO
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
NO				SACRED HEART HOSPITAL-900 SETON DR., CUMB.,		MD. 21502	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:							
4339 IMMEDIATE CAUSE (a) <u>apoplectic stroke</u>							1 1/2 days
DUE TO, OR AS A CONSEQUENCE OF							
(b) <u>arterial thrombosis</u>							1 1/2 days
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>3-25-1969</u> , to <u>3-26-1969</u> , that (I) (we) lost the deceased alive on <u>3-26-1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
<u>L. Brings</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		3-28-69	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
L. BRINGS, M.D.				57 GREENE ST., CUMB., MD. 21502			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		3-29-1969		SS. Peter & Paul Cemetery		Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
SCARPELLI FUNERAL HOME-108 VA. AVE., CUMB., MD.				APR 1 1969		<u>Alfonso Judge</u>	

SCARFELL FUNERAL HOME-100 W. AVE., CUMBERLAND, MD.

M. L. BRIDGES, M.D., 27 GENE ST., CUMBERLAND, MD. 21502

NO

PETE

SCARFELL

(CHESICO) CUMBER

SPRINGFIELD

SCARFELL HOSPITAL-100 SETON ST., CUMBERLAND, MD. 21502

MARYLAND

ALLEGANY CUMBERLAND

101 HANOVER STREET

CUMBERLAND

SCARFELL HOSPITAL

HOSPITAL

ITALY

ALLEGANY COUNTY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
03230											
CERTIFICATE OF DEATH											
03225											
1. DECEASED-NAME (Type or print)			First ELIZABETH			Middle ANNE			Last SCARPELLI		
2a. DATE OF DEATH			Month 12 Day 19 Year 1969			2b. HOUR			12 P M		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH OCT. 12, 1900			6. AGE (In years last birthday) 68 YRS.		
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY Md.		
10. CITY OR TOWN OF DEATH FROSTBURG			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 123 McCULLOH STREET			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSE WORK			12b. KIND OF BUSINESS OR INDUSTRY OWN HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN FROSTBURG			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 123 McCULLOH ST.			14. FATHER'S NAME First LOUIS			Middle ARNONE			Last QUALTIRE		
15. MOTHER'S MAIDEN NAME First CATHERINE			Middle QUALTIRE			Last QUALTIRE			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		
16b. SOCIAL SECURITY NO.			17. INFORMANT CARMELA SCARPELLI, FROSTBURG, MD. 21532			Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HCURO DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs - years -											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(c)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan , 19 69 , to March 12 , 19 69 , that (I) (we) last saw the deceased alive on March 12 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John B. Davis			DEGREE JOHN B. DAVIS, M. D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 3/14/69		
22d. PHYSICIAN'S NAME (Type) JOHN B. DAVIS, M. D.			22e. ADDRESS 2 BROADWAY, FROSTBURG, MD. 21532								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE MAR. 15, 1969			23c. NAME OF CEMETERY OR CREMATORY ST. MICHAELS CEMETERY			23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.		
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. 21532			ADDRESS			25. REC'D BY REGISTRAR MAR 18 1969			25b. REGISTRAR'S SIGNATURE James		

MS-50

51

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03231

CERTIFICATE OF DEATH

03226

1. DECEASED-NAME (Type or print) First Middle Last ANNIE W SCHENBERG			2a. DATE OF DEATH Month Day Year 3 16 1969			2b. HOUR 10:15 P M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 12-9-1888		6. AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (State or foreign country) BALTIMORE		7b. CITIZEN OF WHAT COUNTRY? MARYLAND USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY, Md.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cumberland Nursing Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY —		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3015 NORTHWAY DRIVE	
14. FATHER'S NAME First Middle Last MICHAEL ? WACHTER		15. MOTHER'S MAIDEN NAME First Middle Last MARY ? BETZ							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) NONE		17. INFORMANT LESTER KIEFER MP		Address 622 WASHINGTON ST. Cumberland Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE & PULMONARY CONGESTION 4500 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS, MARKED, Generalized DUE TO, OR AS A CONSEQUENCE OF (c) AGE AND DIET								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 Years Many Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Mesenteric Vasculor Insufficiency; Chronic Colon Syndrome, DIVERTICULOSIS COLON									
19a. DATE OF OPERATION 6-17-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED INTRA-ABDOMINAL ABSCESS		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? None			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 7/6 , 19 68 , to 3/16 , 19 69 , that (I) (we) lost saw the deceased alive on 3/16 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Lester Kiefer MD		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/16/1969			
22d. PHYSICIAN'S NAME (Type) LESTER KIEFER, M.D.		22e. ADDRESS 622 WASHINGTON STREET, Cumberland, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/19/69		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Leonard J Ruck Inc, Baltimore, Maryland		ADDRESS		25a. REC'D BY REGISTRAR MAR 18 1969		25b. REGISTRAR'S SIGNATURE John Carlos Judge			

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OFFICE OF THE SECRETARY

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR		
James Austin Schrock						March 28 1969		4:00 P		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		
Male	White	10/23/13	55 YRS.					Month March Day 28 Year 1969 4:00 P		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Myersdale Pa.		U.S.A.				Allegany Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland Md.			D.O.A. Sacred Heart Hosp.			Retired Salesman		Insurance		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Allegany		Cumberland				837 Mt. Royal Ave.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
Irvin Schrock			Nettie Landis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No					Mrs. James A. Schrock, Cumberland Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CORONARY SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED				
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			March 28 1969				
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) Cumberland, Maryland.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		3/31/69		Myersdale Union Cemetery.		Myersdale Penna.				
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Louis Stein Inc. Cumb. Md.						APR 3 1969		Charles Judge		

FOR FILE
NEED INDEX

03232

MEMO AT EXAMINER'S TESTIMONY OF DEATH

03232

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1020	1021	1022	1023	1024	1025	1026	1027	1028	1029	1030	1031	1032	1033	1034	1035	1036	1037	1038	1039	1040	1041	1042	1043	1044	1045	1046	1047	1048	1049	1050	1051	1052	1053	1054	1055	1056	1057	1058	1059	1060	1061	1062	1063	1064	1065	1066	1067	1068	1069	1070	1071	1072	1073	1074	1075	1076	1077	1078	1079	1080	1081	1082	1083	1084	1085	1086	1087	1088	1089	1090	1091	1092	1093	1094	1095	1096	1097	1098	1099	1100	1101	1102	1103	1104	1105	1106	1107	1108	1109	1110	1111	1112	1113	1114	1115	1116	1117	1118	1119	1120	1121	1122	1123	1124	1125	1126	1127	1128	1129	1130	1131	1132	1133	1134	1135	1136	1137	1138	1139	1140	1141	1142	1143	1144	1145	1146	1147	1148	1149	1150	1151	1152	1153	1154	1155	1156	1157	1158	1159	1160	1161	1162	1163	1164	1165	1166	1167	1168	1169	1170	1171	1172	1173	1174	1175	1176	1177	1178	1179	1180	1181	1182	1183	1184	1185	1186	1187	1188	1189	1190	1191	1192	1193	1194	1195	1196	1197	1198	1199	1200	1201	1202	1203	1204	1205	1206	1207	1208	1209	1210	1211	1212	1213	1214	1215	1216	1217	1218	1219	1220	1221	12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CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
EARL				SEESE	Month 3 Day 9 Year 69		7:55AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS
MALE		WHITE		8-13-03		65 YRS.		IF UNDER 24 HRS. HOURS
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
MARYLAND		U.S.A.				ALLEGANY		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND		MEMORIAL HOSPITAL		Electrician Kelly		Springfield		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
MARYLAND		ALLEGANY		MT. SAVAGE				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT
First Middle Last		First Middle Last		No		212-10-9128		Address
ELMER		SEESE		MARY		EMERICK		CUMBERLAND, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anemia</u> 284X DUE TO, OR AS A CONSEQUENCE OF (b) <u>_____</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>_____</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTINUING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year 19 _____ P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____				
22a. I certify that (I) (this hospital) attended the deceased from <u>4/7/65</u> , 19 <u>65</u> , to <u>3/9/69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/8/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)				
		<u>3/9/69</u>		DR. R. J. WILLIAMS				
22e. ADDRESS		22f. ADDRESS						
		CUMBERLAND, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		Mar. 12, 1969		Mt. Savage, Md. Cemetery		Mt. Savage, Allegany		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
H. rvey H. Zeigler, Hyndman, Pa.				DATE		MAR 12 1969		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ELDER

MEMORIAL HOSPITAL

CAMBERLAND, MD.

DR. R. J. WILLIAMS

CAMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

<div>7-10</div> <div>03234</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>03229</div>																										
1. DECEASED-NAME (Type or print)			First RONALD			Middle D.			Last SHAFFER			2a. DATE OF DEATH Month MARCH			Day 23			Year 1969			2b. HOUR 8:30			Minute M		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH JUNE 13, 1931			6. AGE (In years last birthday) 37 YRS.			IF UNDER 1 YEAR MONTHS			IF UNDER 24 HRS. DAYS			HOURS			MIN.					
7a. BIRTHPLACE (State or foreign country) PENNA.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY																	
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Pittsburgh Plate Glass Employ			12b. KIND OF BUSINESS OR INDUSTRY																	
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE PENNA.			13b. COUNTY BEDFORD			13c. CITY OR TOWN HYNDMAN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER RD. #1, RX.266A														
14. FATHER'S NAME First WILLIAM			Middle SHAFFER			Last PEARL			15. MOTHER'S MAIDEN NAME First May			Middle Holler			Last Holler											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown <input type="checkbox"/>			16b. SOCIAL SECURITY NO. 210-24-6878			17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.																				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of colon with metastasis</u> 1531 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unk.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma Trans Colon			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State																				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																										
22b. SIGNATURE Carter Shaffer MD			DEGREE			ATTENDING PHYS. <input type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 3-25-69.											
22d. PHYSICIAN'S NAME (Type) DR. BRINFIELD			22e. ADDRESS DECATUR ST., CUMBERLAND, MD.																							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE March 26, 1969			23c. NAME OF CEMETERY OR CREMATORY Cooks Mills Cty.			23d. LOCATION (City or Town) (County) (State) Hyndman Bedford Co. Pa.																	
24. FUNERAL DIRECTOR Harvey H. Zeigler, Hyndman, Penna.			ADDRESS			25a. REC'D BY REGISTRAR DATE APR 2 1969			25b. REGISTRAR'S SIGNATURE Charles J. J...																	

1990

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FOR STATE
HEALTH DEPT.

03235

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03230

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR							
Bernice			Victoris			Shumaker			MARCH 9, 1969			9:35 a							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR					
Female		White		Dec. 23, 1910		58 YRS.		MONTHS DAYS		HOURS MIN.		MARCH 9, 1969		9:35 a					
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH										
Maryland			USA						Allegany Md.										
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY							
Cumberland				Memorial Hospital				Housewife				Own Home							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET AND NUMBER			
Md.				Allegany				Cumberland				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				309 south St.			
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last										
J. W. Flora						Harriet E. Kaylor													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS											
no								Mr. Wm. W. Shumaker, Cumberland, Md. Husband											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1. DEATH WAS CAUSED BY:												SUDDEN							
IMMEDIATE CAUSE (a) CORONARY THROMBOSIS, LEFT																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												CORONARY SCLEROSIS							
(b) DUE TO, OR AS A CONSEQUENCE OF												-----							
(c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?							
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
				HOUR A.M. P.M. 19															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.				City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE				Benedict Skitarelic				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED							
EXAMINER'S NAME (Type)				Benedict Skitarelic, m.d.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				March 9, 1969							
								ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)							
Burial				March 12, 1969				Hillcrest Burial Park				Cumberland, Allegany, Md.							
24. FUNERAL DIRECTOR ADDRESS								25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
James F. Scarpelli, Cumberland, Md.								DATE				MAR 11 1969							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

NEW YORK
HEALTH DEPT.

03252

MEDICAL EXAMINER, CITY OF NEW YORK

01210

Name		John J. Smith	
Age		35	
Sex		Male	
Race		Caucasian	
Occupation		Police Officer	
Address		123 Main St., New York, N.Y.	
Date of Birth		Jan 15, 1900	
Place of Birth		New York, N.Y.	
Marital Status		Single	
Education		High School	
Previous Medical History		None	
Current Medical History		None	
Mental Status		Normal	
Physical Examination		Normal	
Diagnosis		None	
Recommendations		None	
Signature of Examiner		[Signature]	
Date of Examination		March 1, 1935	
Signature of Patient		[Signature]	
Date of Signature		March 1, 1935	

FOR STATE HEALTH DEPT.

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03236

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03231

1. DECEASED-NAME (Type or Print)		First OTTO		Middle ORN		Last SILBER		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year		2b. HOUR 3pm	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH OCT. 7, 1880		6. AGE (In years last birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD Month March Day 25 Year 1969	
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) RD 4				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) FARM HAND			12b. KIND OF BUSINESS OR INDUSTRY JENKINS FARM		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RT. 1 (HOFFMAN)			
14. FATHER'S NAME First J. Middle F. Last SILBER				15. MOTHER'S MAIDEN NAME First NANCY Middle SCHWARTZ Last SCHWARTZ							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. 234-26-7034		17. INFORMANT ADDRESS WILMER B. SILBER, R.D. 4, CUMBERLAND, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Coronary Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) --										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED March 25, 1969 ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE MAR. 28, 1969		23c. NAME OF CEMETERY OR CREMATORY FLANAGAN HILL CEMETERY				23d. LOCATION (City or Town) (County) (State) RED CREEK, W. VA.			
24. FUNERAL DIRECTOR JOSEPH R. DURST, FROSTBURG, MD. 21532						25a. REC'D BY REGISTRAR DATE APR 1 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

82580

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
30M REV. 11-68

03237		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03232		
1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month Day Year		2b. HOUR	
CLARENCE				SKIDMORE	MARCH 4 1969		M	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
MALE	WHITE		AUG. 12, 1896		72 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			MD.
MARYLAND	U.S.A.				ALLEGANY			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
FROSTBURG		MINERS HOSPITAL		LABORER - AUTO WRECKERS				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
MARYLAND		ALLEGANY		MIDLOTHIAN		13e. STREET AND NUMBER		
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First Middle Lost
MATTHEW				SKIDMORE	JANE			BONE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT				Address
NO		214-46-3667A		HOWARD SKIDMORE, MIDLOTHIAN, MD.				21543
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Cerebral Hemorrhage</u> <u>4122</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Art. CVD -</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>96 hrs -</u> <u>10 yrs ??</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>3-7</u> , 19 <u>69</u> , to <u>3-4</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3-4</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
						22c. DATE SIGNED <u>3-5-69</u>		
22d. PHYSICIAN'S NAME (Type)		MARTIN ROTHSTEIN, M. D.		22e. ADDRESS 48 BROADWAY, FROSTBURG, MD. 21532				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		MAR. 7, 1969		F.B.G. MEMORIAL PARK		FROSTBURG, MD.		
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
JOSEPH R. DURST, FROSTBURG, MD. 21532				DATE MAR 10 1969		J Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03238

CERTIFICATE OF DEATH

03233

1. DECEASED-NAME (Type or print) Daisy			First J.	Middle Sowers	Last	2a. DATE OF DEATH at 1:30 A.M.			2b. HOUR
						Month March Day 20 Year 1969			M
3. SEX Female		4. RACE White		5. DATE OF BIRTH 8/1/1884		6. AGE (In years lost birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany County			Md.
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Allegany County Infirmary			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housekeeper			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 221 Baltimore Avenue
14. FATHER'S NAME Charles J. Sowers			15. MOTHER'S MAIDEN NAME Margaret Knotts						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. 220-16-6249A		17. INFORMANT P. O. Box 599, Cumberland, Md.				
			Allegany County Infirmary records.						
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute renal insufficiency DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4123 (b) chr ASHDC mitral insufficiency + DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days not known not known	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cerebral arteriosclerosis - Mental deterioration									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Feb. 27, 1969 to March 20, 1969 , that (I) (we) last saw the deceased alive on March 19, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John A. Lepper M.D.					DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 3.20.69
22d. PHYSICIAN'S NAME (Type) John A. Lepper					22e. ADDRESS Memorial Hospital, Cumberland, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/22/69		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery			23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland		
24. FUNERAL DIRECTOR Silcox-Merritt Funeral Service, Cumberland, Md.					ADDRESS 21502		25a. REC'D BY REGISTRAR MAR 24 1969		25b. REGISTRAR'S SIGNATURE Charles Judge

08288

Date

Name

Grade

Address

City

State

Phone

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (Rev. 3-60)

03239		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		03234	
Item# 13e, Film# 410 3/24/69 km CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print)			First Middle Last		2a. DATE OF DEATH Month Day Year
CARL WILLIAM SPITZNAS					MARCH 4, 1969
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	7b. HOUR
MALE	WHITE	DEC. 18, 1891		77 YRS.	3:15 PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH
FROSTBURG, MD.		U.S.A.			ALLEGANY Md.
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
FROSTBURG		MINERS HOSPITAL		CARPENTER OWN BUSINESS	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER
MARYLAND		ALLEGANY	FROSTBURG		226 W. MAIN ST., FROSTBURG
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last		
CHARLES A. SPITZNAS			JULIA BRODE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
YES		W. WAR I		MECHANIC ST., FROSTBURG, MD.	
		217-14-4487		MISS ANNA BELLE SPITZNAS, 226 W.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Primary anemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arterio sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Colectomy 24 yrs. duration</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>2-26, 1969</u> , to <u>3-4, 1969</u> , that (I) (we) last saw the deceased alive on <u>3-4, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		22c. DATE SIGNED			
<u>H.C. Diehl M.D.</u>		<u>3/7/69</u>			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
H.C. DIEHL, M.D.		39 W. MAIN ST., FROSTBURG, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		3/7/69		FROSTBURG MEM. PARK	
				FROSTBURG, ALLEGANY, MD.	
24. NAME OF FUNERAL HOME		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
M. SOWERS		MAR 11 1969		<u>Charles Judge</u>	

08333

CERTIFICATE OF DEATH

01313

CARD: WILLIAM BRITTON MAY 11 1900

DATE: MAY 11 1900

PLACE OF BIRTH: ALABAMA

PLACE OF DEATH: ALABAMA

CAUSE OF DEATH: ...

AGE: ...

SEX: ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

03240		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03235					
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
BESSIE		D		STAHLMAN				Month Day Year MARCH 4 1969		PM 10:56	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 MRS.	
FEMALE		WHITE		10-2-1892		78 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
W. VA.		USA				ALLEGANY					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
CUMBERLAND		MEMORIAL HOSPITAL		HWF.							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MD.		ALLEGANY		ELLERSLIE				BOX 136			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
FRANK		DAVIS				JANE		REED			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address							
NO		188-38-3181		MEMORIAL HOSPITAL, CUMBERLAND, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute lymphocytic leukemia</u>										2 mos	
2040											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
Generalized arteriosclerosis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>1.21.69</u> , 19 <u>69</u> , to <u>3.4.69</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>3.4.69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)		DR. WILLIAM P. JAMES		22e. ADDRESS		441 N. CENTRE ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Mar. 7, 1969		Cooks Mills Cemetery		Hyndman, Bedford, Pa.		RD			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Harvey H. Zeigler, Hyndman, Pa.				DATE MAR 10 1969		J Charles Judge					

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MEMORIAL HOSPITAL, CUMBERLAND, MD.

Acute lymphocytic leukemia

Generalized arteriosclerosis

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DR. WILLIAM P. JAMES

DR. H. CENTRE ST., CUMBERLAND, MD.

MAR 19 1969

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03241		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03236					
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last Lavada Ola Sturtz					2a. DATE OF DEATH Month Day Year March 25 69			2b. HOUR 10A M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH August 31, 1897			6. AGE (In years lost birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Penna		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegheny Md.					
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Miners Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Penna		13b. COUNTY Somerset		13c. CITY OR TOWN Hyndman		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RD#1			
14. FATHER'S NAME First Middle Last Daniel Troutman					15. MOTHER'S MAIDEN NAME First Middle Last Cordelia Clites						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 215-10-1242B		17. INFORMANT Address Ralph S. Sturtz, Hyndman, Pa. RD#1							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC BRAIN SYNDROME</u> <u>4379</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>2 YEARS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CHRONIC URINARY TRACT INFECTION</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>March 7, 1969</u> , to <u>March 25, 1969</u> , that (I) (we) lost saw the deceased alive on <u>March 24, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>A. Paige Strong</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>3/25/69</u>				
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>March 28, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cooks Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Wellersburg, Somerset Co., Pa.</u>				
24. FUNERAL DIRECTOR <u>Harvey H. Zeigler</u>					ADDRESS <u>Hyn dman, Pa. 15545</u>		25a. REC'D BY REGISTRAR <u>APR 1 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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FOR STATE
HEALTH DEPT.

03242

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03237

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year			2b. HOUR		
JACK WILLIAM THARP						March 12, 1969			1:55 a		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR
MALE	WHITE	DEC. 21, 1950	18 YRS.	MONTHS	DAYS	HOURS	MIN.	March 12, 1969			1:55 a
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
MARYLAND		U.S.A.					ALLEGANY				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			Memorial Hospital			ATTENDANT -			SERVICE STATION		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND				ALLEGANY		FROSTBURG		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		ROUTE 2	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
JACK WILLIAM THARP			VIRGINIA DICKEY								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
NO			215-56-8708		JACK W. THARP, SR., FROSTBURG, MD. RT. 2						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Asphyxiation, (blood in bronchi)										minutes	
8120 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										70 Minutes	
(b) Rupture of Right Lung											
DUE TO, OR AS A CONSEQUENCE OF											
(c) Compression and Fracture ribs, right										70 Minutes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
				12:15 P.M. March 12, 1969		Driver of Automobile in one car wreck					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
		Route 220, 500 feet south of State Line,		Pa		Allegany, Maryland					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED			
BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				March 12, 1969			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)			
				CUMBERLAND, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
BURIAL		MAR. 15, 1969		F.B.G. MEMORIAL PARK		FROSTBURG, MD.					
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
JOSEPH R. DURST, FROSTBURG, MD. 21532						MAR 18 1969		[Signature]			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

9250

RECEIVED: 11/11/11

2001, 51, 107-110

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in parentheses in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-9. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03243

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03238

1. DECEASED-NAME (Type or Print) Robert Scott Thomas			2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> March 24, 1969			2b. HOUR 2:30 A.M.			
3. SEX Male	4. RACE White	5. DATE OF BIRTH Dec. 12, 1949	6. AGE (In years last birthday) 19 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year March 24, 1969			2d. HOUR 2:30 A.M.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany			
10. CITY OR TOWN OF DEATH Cumberland,		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital--DOA			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Brakeman,		12b. KIND OF BUSINESS OR INDUSTRY B. & O. Rwy.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland,		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1000 McMullen Hwy.	
14. FATHER'S NAME First Middle Last William D. Thomas			15. MOTHER'S MAIDEN NAME First Middle Last Mildred D. Hinebaugh			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.			
16b. SOCIAL SECURITY NO. 215-56-9157			17. INFORMANT Mr. W. Mitchell Thomas,			ADDRESS Takoma Park, Md. 8212 Flower Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Hemorrhage 819.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Skull Fracture DUE TO, OR AS A CONSEQUENCE OF (c) Sudden									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes,
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 1:30 P.M. Mar. 24, 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Automobile Accident (one car)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Highway		21f. LOCATION Street or R.F.D. No. City or Town County State Winchester Road, Cumberland, Allegany, Maryland					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Benedict Skitarelic		EXAMINER'S NAME (Type) Benedict Skitarelic, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED March 24, 1969			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/27/69		23c. NAME OF CEMETERY OR CREMATORY I. O. O. F. Cemetery		23d. LOCATION (City or Town) (County) (State) Salisbury, Somerset, Penna.			
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE APR 1 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

THE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 11-69

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First BERTHA			Middle HENDRICKS			Last TIPTON			2a. DATE OF DEATH Month Day Year 3 6 69			2b. HOUR 3:15P M		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH 3-22-88			6. AGE (In years last birthday) 80 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY								
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife,			12b. KIND OF BUSINESS OR INDUSTRY Own home								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CUMBERLAND			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER RT. 4					
14. FATHER'S NAME First Middle Last ROBERT S. POLLOCK			15. MOTHER'S MAIDEN NAME First Middle Last EMMA V. GRACE														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) no,			16b. SOCIAL SECURITY NO. 220-52-9539			17. INFORMANT MEMORIAL HOSPITAL						Address CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial thrombosis</u> 4442 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 10 yrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Arteriosclerotic organic brain syndrome & dementia (senile)</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.O. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>2-19, 1969</u> , to <u>3-6, 1969</u> , that (I) (we) last saw the deceased alive on <u>3-6, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Vasquez P. Dross MD</u>			22c. DATE SIGNED 3-9-69			22d. PHYSICIAN'S NAME (Type) DR. V. DROSS			22e. ADDRESS CUMBERLAND, MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 3/9/69			23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery,			23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.								
24. FUNERAL DIRECTOR H. Wayne George			ADDRESS Cumberland, Md.			25a. REC'D BY REGISTRAR DATE MAR 11 1969			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>								

MEDICAL CERTIFICATION

H. Wayne George Cumberland, Md.

MAR 1 1959

Grantee 3/9/59

James Monroe Cemetery, Cumberland, Maryland, Md.

DR. V. DROSS

CUMBERLAND, MD.

MD.

250-55-0539

MEMORIAL HOSPITAL, CUMBERLAND, MD.

HERBERT S.

FOLLOCA

ELIA

V.

RACE

MARY AND

ALLEGANY

CUMBERLAND

W. H.

CUMBERLAND

MEMORIAL HOSPITAL

Houshock,

Old name

MARY AND

U.S.A.

ALLEGANY

WHITE

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HENRICKS

TITEL

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62-3-151

03244

03234

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03245

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03240

1. DECEASED-NAME (Type or Print)			First Middle Lost			2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year			2b. HOUR		
Lawrence Upton Turner						OF ESTI- DEATH MATED <input type="checkbox"/> March 31 '69			3:55a		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Year Day			2d. HOUR
Female	White	May 7, 1899	69 YRS.					March 31, 1969			3:55a M.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
W. Va.		USA				Allegany Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			Memorial Hospital			Custodian-Board of Education					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Md.			Allegany			Cumberland			1209 Lexington Ave.		
14. FATHER'S NAME First Middle Lost			15. MOTHER'S MAIDEN NAME First Middle Lost								
William Robey			Anna Celevenger								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS					
						Mr. Guy Robey, Cumberland, Md. Brother					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4109</u> (b) <u>CORONARY SCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> <u>--</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.				City or Town		County State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED							
EXAMINER'S NAME (Type)		BENEDICT SKITARELIC, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		March 31, 1969					
				ADDRESS (Street, city, town, or county)		CUMBERLAND, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Apr. 2, 1969		Rest Lawn Memorial Park		La Vale, Allegany, Md.					
24. FUNERAL DIRECTOR ADDRESS				25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
James F. Scarpelli, Cumberland, Md.				DATE APR 3 1969		[Signature]					

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2021-2022

U. S. DEPARTMENT OF COMMERCE

2015, 1E, 0-215-179

• **EM**

Edgar Allan Poe

THE UNIVERSITY OF CHICAGO


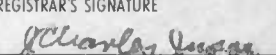
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地址：上海南京路100号

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
03246		03241															
1. DECEASED-NAME (Type or print)			First CHESTER			Middle W.			Last TWIGG			2a. DATE OF DEATH MARCH Month 5 Day 1969			2b. HOUR 2:45A		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 10-3-1893			6. AGE (In years last birthday) 75 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) W. VA.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY			Md.					
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Material Distributor			12b. KIND OF BUSINESS OR INDUSTRY Railroad								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. VA.			13b. COUNTY Hampshire			13c. CITY OR TOWN GREENSPRING			13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO			13e. STREET AND NUMBER None					
14. FATHER'S NAME First BENJAMIN			Middle TWIGG			Last FOLEY			15. MOTHER'S MAIDEN NAME First CATHERINE			Middle FOLEY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service) no			16b. SOCIAL SECURITY NO. 104-02-2469			17. INFORMANT MEMORIAL HOSP., CUMBERLAND, MD.			Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atrial Fibrillation, Chronic Myocarditis DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Heart Failure - Diabetes Mellitus												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4109 hours					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 2-24-69 , 19____, to 3-5-69 , 19____, that (I) (we) lost the deceased alive on 3-4-69 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE 			DEGREE DR. HIMMELWRIGHT			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 3-5-69								
22d. PHYSICIAN'S NAME (Type) DR. HIMMELWRIGHT			22e. ADDRESS 133 VA. AVE., CUMBERLAND, MD.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE March 7, 1969			23c. NAME OF CEMETERY OR CREMATORY Forest Glen Cemetery			23d. LOCATION (City or Town) (County) (State) Near Greenspring, W. Va.								
24. FUNERAL DIRECTOR SCARPELLI FUNERAL HOME, CUMBERLAND, MD			ADDRESS			25a. REC'D BY REGISTRAR DATE MAR 7 1969			25b. REGISTRAR'S SIGNATURE 								

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**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>Item 5 Film 410 3/27/69</div> <div>03247</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div>													
1. DECEASED-NAME (Type or Print) Emma G. Wagner						2a. DATE KNOWN OF DEATH MATED March 20, 1969		2b. HOUR 2:28 M		2c. DATE PRONOUNCED DEAD Month March Day 20 Year 1969		2d. HOUR 2:28 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Feb. 29, 1892		6. AGE (In years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0		7c. DATE PRONOUNCED DEAD Month March Day 20 Year 1969	
7a. BIRTHPLACE (State or foreign country) Oldtown Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Allegany				
10. CITY OR TOWN OF DEATH Cumberland Md.				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL-DOA				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 37 Weber Street			
14. FATHER'S NAME First George A. Middle Kifer Last 						15. MOTHER'S MAIDEN NAME First Margaret Middle Dill Last 							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO. (If yes give war or dates of service) None		17. INFORMANT ADDRESS Memorial Hosp. Records, Cumberland Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: 4442 IMMEDIATE CAUSE (a) GANGRENE OF BOWEL												About 24 Hrs.	
DUE TO, OR AS A CONSEQUENCE OF (b) MESENTERIC THROMBOSIS												" "	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arteriosclerosis												-----	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Fracture of Left Hip													
19a. DATE OF OPERATION December 12, 1969-1768				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fracture of Left Hip						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 9:00 PM Dec. 10 19 68				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fell while getting out of bed.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home				21f. LOCATION Street or R.F.D. No. 37 Weber St. City or Town Cumberland County Allegany State Maryland					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED					
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 20, 1969					
				ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 3/23/69		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park				23d. LOCATION (City or Town) (County) (State) Cumberland Md. (Allegany)			
24. FUNERAL DIRECTOR <i>Louis Stein Inc.</i> ADDRESS Louis Stein Inc. 117 Frederick St. Cumb. Md.						25a. REC'D BY REGISTRAR DATE MAR 24 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

53200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																			
03248																			
03243																			
CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print)			First CHARLES			Middle 1.		Last WARD		2a. DATE OF DEATH Month MARCH		Day 8,		Year 1969		2b. HOUR 1:03			
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH JUNE 26, 1903			6. AGE (In years last birthday) 65 YRS.			IF UNDER 1 YEAR MONTHS 		IF UNDER 24 HRS. DAYS 		HOURS 		MIN. 	
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY										
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) MINER			12b. KIND OF BUSINESS OR INDUSTRY COAL										
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN FROSTBURG			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 376 WELSH HILL							
14. FATHER'S NAME First WILLIAM			Middle 			Last WARE			15. MOTHER'S MAIDEN NAME First MARY			Middle J.			Last TAYLOR				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, or unknown) NO			(If yes, give war or dates of service) N.A.			16b. SOCIAL SECURITY NO. 213-09-6591			17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, Failure 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. long standing atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF hypertension APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) He had been treated for a long time for a heart condition.																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that (I) (this hospital) attended the deceased from March 1, 1968 to March 8, 1968 that (I) (we) lost saw the deceased alive on March 7, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE B. Schindler			DEGREE DR. B. SCHINDLER			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 3/8/69										
22d. PHYSICIAN'S NAME (Type) DR. B. SCHINDLER			22e. ADDRESS 43 GREENE ST., CUMBERLAND, MD.																
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 3/10/69			23c. NAME OF CEMETERY OR CREMATORY ECKHART CEMETERY			23d. LOCATION (City or Town) (County) (State) ECKHART ALLEGANY, MD.										
24a. PREPARED BY MARTIN M. SOWERS			24b. PREPARED BY HAFFER-SOWERS FUNERAL HOME			24c. ADDRESS 60 W. MAIN, FROSTBURG			25a. REC'D BY REGISTRAR MAR 14 1969			25b. REGISTRAR'S SIGNATURE J. Charles Judge							

03844

RECORD OF DEATH

CHARGES

WAGE

WAGE

AGE

WHITE

DATE OF BIRTH

GRAVE NO.

U.S.A.

X

ALLEGANY

C. BERNARD

GENERAL HOSPITAL

COAL

ALLEGANY

ALLEGANY

3-6 WEST

WILLIAM

WAGE

WAGE

WAGE

WAGE

N.Y.

TO

213-00-6501

GENERAL HOSPITAL, ALLEGANY, MD.

DR. B. SCHINDLER

13 GREENE ST., CANTON, MD.

BURIAL

213-00-6501

ALLEGANY

ALLEGANY

ALLEGANY, MD.

ALLEGANY, MD. 1983

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03249

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03244

1. DECEASED-NAME (Type or Print)		First WILLIAM		Middle		Last WARE		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> MARCH 2, 1969		Month Day Year		2b. HOUR 3a M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH OCT. 31, 1917		6. AGE (in years last birthday) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MARCH 3, 1969		2d. HOUR 7 p M			
7a. BIRTHPLACE (State or foreign country) FROSTBURG, MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY						Md.			
10. PLACE OF DEATH HOMWOOD ADDITION CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in home, give street address) HOMWOOD TAVERN Rt. 36, R.F.D. CUMBERLAND		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MANAGED TAVERN REST. *TAV.		12b. KIND OF BUSINESS OR INDUSTRY									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND		13b. COUNTY ALLEGANY CUMBERLAND		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET AND NUMBER RT. 36, R.F.D. CUMBERLAND									
14. FATHER'S NAME JOHN		First WARE		Middle		Last MARY		15. MOTHER'S MAIDEN NAME MARY		First BENNETT		Middle MARYLAND			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. N.A.		16c. 216-05-0571		17. INFORMANT MRS. JOHN SMITH, WELSH HILL, FROSTBURG,		ADDRESS MARYLAND							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS, LEFT 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CORONARY SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) ----															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED March 3, 1969							
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE 3/6/69				23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM. PARK				23d. LOCATION (City or Town) (County) (State) FROSTBURG, ALLEGANY, MD.			
24. BY MARY M. SOWERS, HAFFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG				25a. REC'D BY REGISTRAR Charles Judge				25b. REGISTRAR'S SIGNATURE Charles Judge				DATE MAR 11 1969			

03300

UNITED STATES DEPARTMENT OF JUSTICE

10 MARCH 1963

MEMO

TO :

10 MARCH 1963

FROM :

SUBJECT: ...

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...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03250		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03245	
1. DECEASED-NAME (Type or print)		First ROSE	Middle NMI	Last WEAVER	2a. DATE OF DEATH 3 Month 19 Day 69 Year		2b. HOUR 2:55 M
3. SEX FEMALE	4. RACE WHITE		5. DATE OF BIRTH 9-17-86		6. AGE (In years last birthday) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? US OF A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Waitress & cook		12b. KIND OF BUSINESS OR INDUSTRY Public school	
13a. USUAL RESIDENCE (Where deceased admission) STATE MD.		13b. CITY OR TOWN ALLEGANY		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Winchester Road,	
14. FATHER'S NAME First FRANK		Middle	Last PELICAN	15. MOTHER'S MAIDEN NAME First AGATHA		Middle BARKOWSKI	Last *****
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 217-10-4483		17. INFORMANT Address 900 SETON DR. CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>unl</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Acute Bronchopneumonia</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/18</u> , 19 <u>68</u> , to <u>3/19</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/19</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>J. A. Pagan</u>		22c. DATE 3/19/69		22d. PHYSICIAN'S NAME (Type) J. A. PAGAN, MD		22e. ADDRESS 1068 NATIONAL HWY., LA VALE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3/22/69		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park,		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.	
24. FUNERAL DIRECTOR H. Wayne George		ADDRESS GEORGE ; FUNERAL HOME, 202 GREENE ST., CUMB.		25a. REC'D BY REGISTRAR DATE MAR 24 1969		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03251

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03246

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month Day Year			2b. DATE PRONOUNCED DEAD Month Day Year		
Christian Wilson Weisenmiller						March 27, 1969			March 27, 1969		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR P M
Male	White	Feb. 10 1899	70 YRS.					March 27, 1969			3:45 P M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
WVa.		USA.				Allegany Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			Sacred Heart Hospital-DOA			Brewery Worker			Brewery		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Allegany			Cumberland				735 Fayette St.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
John Wm. Weismiller			Anna Smitt								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS					
No						Mary I. Weisenmiller 735 Fayette St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Benedict Skitarelic, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED			
EXAMINER'S NAME (Type)		Benedict Skitarelic, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		March 27, 1969			
ADDRESS (Street, city, town, or county) Cumberland, Maryland.											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Mar. 31, 1969		Hillcrest Burial Park		Cumberland Allegany Md.					
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
Louis Stein Inc. 117 Frederick St.						APR 3 1969		Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03252		CERTIFICATE OF DEATH						03247	
1. DECEASED-NAME (Type or print)		First GEORGE		Middle W.	Last WELLINGS, SR.		2a. DATE OF DEATH Month 2 Day 1969 or		2b. HOUR 3 P M
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH AUGUST 9, 1888		6. AGE (In years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY		Md	
10. CITY OR TOWN OF DEATH FROSTBURG		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MINERS HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) MINER		12b. KIND OF BUSINESS OR INDUSTRY COAL MINES			
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 207 UPPER CONSOL RD.	
14. FATHER'S NAME First HENRY		Middle WELLINGS		Last 15. MOTHER'S MAIDEN NAME First SARAH		Middle A.		Last LEWIS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. 213-09-6553		17. INFORMANT ROBT. WELLINGS, FROSTBURG, MD.		Address 163 S. WATER ST.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right ventricular failure</u> 4122 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>HCV</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks. years-									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>69</u> , to <u>March 2</u> , 19 <u>69</u> , that (I) (<u>was</u>) last saw the deceased alive on <u>3/2/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>was</u>) (did) (<u>did not</u>) view the body after death.									
22b. SIGNATURE <u>John B. Davis MD.</u>		22c. DATE SIGNED 3/4/69.		22d. PHYSICIAN'S NAME (Type) JOHN B. DAVIS, M. D.					
22e. ADDRESS BROADWAY, FROSTBURG, MD. 21532									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE MAR. 5, 1969		23c. NAME OF CEMETERY OR CREMATORY FGB. MEMORIAL PARK		23d. LOCATION (City or Town) FROSTBURG, MD.		(County) (State)	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. 21532		25a. REC'D BY REGISTRAR MAR 6 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
03253 CERTIFICATE OF DEATH 03248											
1. DECEASED-NAME (Type or print)			First JOHN Middle W. Last WHEITZEL			2a. DATE OF DEATH Month MARCH Day 28, Year 1969			2b. HOUR PM 6:35		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 3-15-1893		6. AGE (In years last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) W.VA.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY			Md.		
10. CITY OR TOWN OF DEATH CUMBERLAND,			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during last working life, even if retired.) Trackman			12b. KIND OF BUSINESS OR INDUSTRY Railroad		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 302 ARCH ST.		
14. FATHER'S NAME First GEORGE Middle WHETZEL Last			15. MOTHER'S MAIDEN NAME First MARY Middle LEWIS Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>4122</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>George M. Simons</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <u>3/31/69</u>						
22d. PHYSICIAN'S NAME (Type) DR. W. P. JAMES Dr. George M. Simons					22e. ADDRESS CUMBERLAND, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-31-1969		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.			23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany				
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.					25a. REC'D BY REGISTRAR APR 3 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

03222

JOHN

WHEITZEL

MARCH

WIFE

WHITE

3-12-1823

NO

W.VA.

U. S. A.

X

ALLEGANY

CUMBERLAND,

MEMORIAL HOSPITAL

RETIRED

W.VA.

ALLEGANY CUMBERLAND

X

302 APRIL ST.

GEORGE

WHEITZEL

MARY

LEWIS

MEMORIAL HOSPITAL, CUMBERLAND, MD.

DR. W. R. JAMES, JR., CUMBERLAND, MD.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03254										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03249																													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																																																	
1. DECEASED-NAME (Type or Print) Jesse W. White										2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 3-15-69 19										2b. HOUR 7 p M																													
3. SEX Male			4. RACE White			5. DATE OF BIRTH 3-7-1888			6. AGE (in years last birthday) 81 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.			2c. DATE PRONOUNCED DEAD Month March Day 15 Year 1969 19										2d. HOUR 7 p M																					
7a. BIRTHPLACE (State or foreign country) West Virginia					7b. CITIZEN OF WHAT COUNTRY? UAS					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Allegany										Md.																								
10. CITY OR TOWN OF DEATH Cumberland					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital—DOA										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Celanese										12b. KIND OF BUSINESS OR INDUSTRY Textile																								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland										13b. COUNTY Allegany										13c. CITY OR TOWN Cumberland										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER R.D. #1 Locust Grove									
14. FATHER'S NAME First Sylvester Middle — Last White										15. MOTHER'S MAIDEN NAME First Unknown Middle — Last —																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW I										16b. SOCIAL SECURITY NO.										17. INFORMANT Hospital Record										ADDRESS																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) —																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>										22b. DATE SIGNED																													
ACTUAL SIGNATURE Benedict Skitarelic M.D.										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 15, 1969																													
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.										ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND																																							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					23b. DATE 3-18-69					23c. NAME OF CEMETERY OR CREMATORY Hill Crest Burial Park					23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.																																		
24. FUNERAL DIRECTOR Louis Stein Inc.										ADDRESS Louis Stein, Inc.--117 Frederick St. Cumberland										25a. REC'D BY REGISTRAR MAR 19 1969										25b. REGISTRAR'S SIGNATURE Charles Judge																			

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UNITED STATES DEPARTMENT OF AGRICULTURE

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03255

03250

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year			2b. HOUR
Raymond Miller Whiteman						March 10 '69			9 a.m.
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Male	White	Feb. 7, 1893	76 YRS.					March 10, 1969	19 10:00a.m.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.
West Virginia		USA				Allegany			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
La Vale		Routel, 8 Locust Grove		Retired Rubber Worker		Kelly			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER			
Maryland			Allegany	La Vale		Route 1, Locust Grove			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Charles Bradford Whiteman			Virginia Bean						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No			214-05-4369		Emma Whiteman, Locust Grove, La Vale				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN ---	
CORONARY OCCLUSION CORONARY SCLEROSIS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Benedict Skitarelic			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			BENEDICT SKITARELIC, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			March 10, 1969
			ADDRESS (Street, city, town, or county)			Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		Mar. 13, 1969	Indian Mound Cemetery		Romney Hampshire W. Va.				
24. FUNERAL DIRECTOR John J. Hafer, Jr.			ADDRESS 230 Balto Ave. Cumberland Md			25a. REC'D BY REGISTRAR MAR 14 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03256

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03251

1. DECEASED-NAME (Type or Print)			First NEVA			Middle PEARL			Last WILSON			2a. DATE KNOWN OF DEATH Month Day Year ESTIMATED <input checked="" type="checkbox"/> MAR. 10 1969			2b. HOUR 1:45 P.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH 6-19-1889		6. AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year MARCH 10 1969			2d. HOUR 1:45 P.				
7a. BIRTHPLACE (State or foreign country) Penna				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Allegany Md.							
10. CITY OR TOWN OF DEATH Cumberland Rt2				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) P.O. Box 156						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housekeeper				12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Allegany				13c. CITY OR TOWN Cumberland				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER P.O. Box 156 - Rt 2					
14. FATHER'S NAME First Middle Last David Rieger						15. MOTHER'S MAIDEN NAME First Middle Last Florence Miller													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 214-05-5508B						17. INFORMANT ADDRESS Rt #2- P.O Bx 156 Cumberland, Md Joseph H. Wilson, Sr							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CORONARY SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED							
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						MARCH 10, 1969							
						ADDRESS (Street, city, town, or county) CUMBERLAND, MD.													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 3/13/69		23c. NAME OF CEMETERY OR CREMATORY Zion Memorial Park				23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland									
24. FUNERAL DIRECTOR ADDRESS 21502 Silcox-Merritt Funeral Service Cumberland, Md						25a. REC'D BY REGISTRAR DATE MAR 13 1969			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>										

03222

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03221

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John Doe		45		Male		White		10/15/1998		New York, NY	
Cause of Death		Manner of Death		Occupation		Education		Marital Status		Social Security Number	
Heart Disease		Natural		Teacher		High School		Married		123-45-6789	
Medical History		Previous Illnesses		Allergies		Medications		Surgical History		Other Notes	
Hypertension		Asthma		None		Aspirin		Appendectomy		No other significant findings	
Family History		Genetic Disorders		Infectious Diseases		Chronic Conditions		Trauma History		Autopsy Performed	
None		None		None		None		None		No	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Medical Director		Signature of Registrar		Signature of Clerk	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Examination		Time of Examination		Location of Examination		Witnesses		Remarks		Remarks	
10/15/1998		10:00 AM		New York, NY		John Doe, Jane Doe		Deceased was found at home		No other significant findings	

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03257

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03252

1. DECEASED-NAME (Type or print) JESSE		First	Middle	Last	2a. DATE OF DEATH Month 5 , Year 1969		2b. HOUR 2:10 PM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 6-29-1916		6. AGE (In years last birthday) 52 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) ALLEGANY CO INFIRMARY		12b. KIND OF BUSINESS OR			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. CITY OR TOWN WESTERNPORT		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 126 WAVERLY ST.			
14. FATHER'S NAME First THOMAS Middle P. Last WILT		15. MOTHER'S MAIDEN NAME First ELIZABETH Middle BITTINGER Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give branch or date of service) Yes		16b. SOCIAL SECURITY NO. 212-18-1979		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CRUISE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 2/25/69 , to 3/5/69 , 19__, that (I) (we) last saw the deceased alive on 3/5/69 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R. J. Williams		22c. PHYSICIAN'S NAME (Type) R. J. WILLIAMS		DEGREE ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. DATE SIGNED 3/9/69			
22e. ADDRESS CUMBERLAND, MD.									
23a. BURIAL, CREMATION, or other disposition Buried		23b. DATE 3/8/69		23c. NAME OF CEMETERY OR CREMATORY Philos		23d. LOCATION (City or Town) (County) (State) Westernport, Allegany Md			
24. FUNERAL DIRECTOR E. L. Brial		ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR DATE MAR 13 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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30756

WILL

MARCH 2, 1969

1:10

WILE

WHITE

6-25-1916

25

MARYLAND

U. S. A.

X

ALLEGANY

CUMBERLAND

MEMORIAL HOSPITAL

MARYLAND

ALLEGANY HOSPITAL

X

120 WARELY ST.

THOMAS

P. WILL

ELIZABETH

BITTNER

100

W. S. S.

6-25-1916

MEMORIAL HOSPITAL, CUMBERLAND, MD.

WILLIAM

CUMBERLAND, MD.

100

W. S. S.

6-25-1916

MARCH 2, 1969

ALLEGANY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 116

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
03258										
CERTIFICATE OF DEATH										
03253										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Victoria Frances Wolfe						March 3, 1969		10:35 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Female		White		10/9/1874		94 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
West Virginia		U. S. A.				Allegany County				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			Allegany County Infirmary			Housewife		Own Home		
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Allegany		Cumberland		YES		1404 Virginia Avenue	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
John Conrad			Martha Rosebrook							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT					
no					P.O. Box 599, Cumberland, Md. Allegany County Infirmary records.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>CVA</u>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) <u>Generalized arteriosclerosis</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c) <u>hypertension</u>										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
<u>1 week</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
MEDICAL CERTIFICATION										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year								
		P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from May 1, 1959, to March 3, 1969, that (I) (we) lost saw the deceased alive on March 3, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE										
<u>George M. Simon</u>										
22c. DATE SIGNED										
<u>March 6, 1969</u>										
22d. PHYSICIAN'S NAME (Type)										
<u>G. M. Simon</u>										
22e. ADDRESS										
<u>Memorial Hospital, Cumberland, Md.</u>										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		3-6-69		Hillcrest Burial Park		Cumberland, Md.				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James F. Scarpelli Cumberland, Md					DATE MAR 7 1969		<u>Charles Judge</u>			

08258

STATE OF NEW YORK

08258

IN SENATE
January 10, 1907
REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 10, 1906
ALBANY: J.B. LIPPINCOTT & CO. PRINTERS
1907

ALBANY: J.B. LIPPINCOTT & CO. PRINTERS
1907